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ABSTRACT

Preliminary data are reported on the impact of the national Parent-Child Center Program (PCC), related to what is termed an immediate criterion of impact. The information summarizes numbers of families served and types of services provided, without evaluative interpretation. Introductory remarks give information on the purpose of the report, background, method of procedure, and instruments used. Chapters then focus on 1) parents: who they are, what they do at the PCC, what has happened as a result of PCC membership, objective and subjective measures of its impact; 2) children: who they are, what they do, and what has happened as a result of their PCC membership; and 3) staff: who they are, what they do, and the impact of PCC on them. Data are gathered from questionnaires and individually conducted interviews. (LH)

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REPORT ON PRELIMINARY IMPACT DATA FROM A NATIONAL SURVEY OF THE PARENT-CHILD CENTER PROGRAM

Prepared for
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Our very special thanks go to the Directors, staff, and parents of the Parent Child Centers. Across the country and at every Center, staff and parents were helpful, cooperative, and available to us for interviews and explanation. We deeply appreciate the extent of this cooperation which made field work a genuine pleasure.

We are thankful for all this assistance and cooperation. As usual, the faults in the study thus far and in this report on preliminary impact rest with the project staff.

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SUMMARY

Introduction

This summary and the discussion of findings which follows derive from the data obtained in the first part of a two-phase study. The first phase was originally to generate information which could be used in grouping Parent-Child Centers according to similarities of operations, objectives and staff or membership attitudes.

Data collection instruments were then expanded to obtain a wider range of enumerative data relating to preliminary impact -- generally speaking, estimates of how many PCC members are receiving various types of services, and by what means. This document covers those preliminary impact data. Phase II of the study is to be an investigation of impact in greater depth by evaluating the progress of fixed samples of member families over time.

Procedure

Thirty-two of the 33 Parent-Child Centers currently under the direction of the Office of Child Development (OCD) were visited by Center for Community Research (CCR) interviewers between October, 1971, and January, 1972. Only the Alaskan PCC was omitted from this study phase.

Individual face-to-face interviews were conducted with 385 PCC member parents and with 327 Center staff members. Additionally, Directors (or their professional staff delegates) filled out comprehensive forms treating all major aspects of

PCC function: goals, staffing, educational programs, medical/dental/nutritional services, and social/counseling services.

Parents of the PCC's

In overall terms CCR found that:

1. More than 2,600 adults are currently engaged in Center activities of one kind or another. There were 1,799 mothers, 512 fathers, and more than 300 other adults taking part in programs.
2. Parent sample data show that the typical mother is in her twenties, although one quarter of those interviewed were in their thirties. Relatively few teenage mothers were encountered.
3. An average of 3.5 children were reported by respondents, with an average of 1.5 focal children enrolled per family.
4. One fourth of the parents sampled had completed high school. One third had some high school education, while another fourth had stopped short of the tenth grade.
5. The great majority of urban families are Black, while the preponderance of rural members were of Mexican or other Caucasian ancestry.

6. Two fifths of all families represented in the sample were intact. That proportion was considerably higher in rural than in urban areas.

Almost all of the above findings are consistent with data reported by Kirschner Associates Inc. (KAI) in their national survey of PCC's two years ago. The one striking exception involves the number of fathers participating, which has risen from almost none to more than 500 in the interim.

Services received by parents

Parent-Child Centers have secured a wide variety of health, educational and social benefits to their memberships:

1. Almost half (47%) of all parents have received medical aid, that figure being higher in rural areas (62%) than urban ones (39%).
2. Dental care is secured for parents only about half as often (23%), with rural residents again being the more likely recipients.
3. Enrollment in parent education curricula at the Centers or as part of PCC outreach has increased sharply since the KAI study. Involvement in home management subjects has more than tripled. For example, 1,081 parents are reported now to be taking nutrition or menu planning courses. Only 322 were doing so two years ago. Consumer education enrollment has risen from 262 to 962.

4. Skill training and job counseling are provided for participants as well: for example, 327 parents are now receiving preparation for child care careers.

5. Eleven Centers report adult basic education courses, with an average of ten Graduate Equivalence Diplomas (G.E.D.'s) completed among current enrollees and a total of 121 more in the process of doing so. Also, 15 PCC's have college affiliations involving a total of 157 parents. Thirty have completed these programs, almost half receiving associate or vocational degrees.

6. Centers report in aggregate more than 6,000 referrals made to community agencies of all types within the last program year. More than 500 referrals have been received <u>from</u> such organizations.

7. Slightly more enrolled families are receiving welfare aid now than before becoming members, and slightly more have at least one member employed now. Centers have facilitated economic support in both ways.

8. Of particular note is the fact that 210 currently or formerly enrolled parents are employed at PCC's, versus 146 two years ago. All but nine Centers hire parents, and a few mothers are even holding positions of professional responsibility.

Attitudes of parents toward PCC

Self-report of what PCC has done for their families and for themselves in different roles (e.g., as mothers, as homemakers, as individuals) elicited an overwhelmingly favorable response.

1. Overall, 95% of the parents interviewed stated that PCC has had a positive impact on their lives. Mentions of educational aspects were most frequent, but there were also a significant proportion who referred to marked development of openness and self-confidence for themselves and/or for their children.
2. A great preponderance of mothers also noted gains in their approach to motherhood. Major mentions involved decrease in corporal punishment, increase in recognition of the needs of children or an attendant ability to meet those needs, and, simply, greater enjoyment of children.
3. A somewhat smaller proportion of mothers said that they had changed as homemakers. Many consider that they have been competent all along. Others, though, report that they have learned to budget better, and that they take increased pride in keeping a neat home and in serving better meals.

4. Approximately 40% of the sample also related that their feelings have changed just as human beings. Decreases in feelings of shyness, isolation or depression predominated.
5. Those few relating negative aspects focused on a variety of problems. Lack of assistance toward a career was most frequently brought up, although others pointed to a failure of educational programs or just to general confusion and lack of organization at certain Centers.

Focal children

In overall description of the children enrolled, CCR finds that:

1. A total of 3,174 youngsters are currently served, an average of almost 100 per Center.
2. The average age of the focal child is 26 months. There are slightly more runabouts (approximately age two and one half or older) than toddlers (between one and two and one half), and slightly more toddlers than infants.

Centers vary considerably in the approaches they have adopted for serving children:

1. Twice as many children are served at the PCC itself as are served in the home as part of outreach. More than 500 are served in both locations.
2. Approximately half of the PCC's utilize elements of a structured developmental model. Eight report following some Montessori elements and a total of 15 mention having a structured or packaged learning approach in whole or in part. Most Centers reported using an approach of general child development (26 of them) or a generally supportive setting (22) or both.
3. The relative importance Directors impute to various developmental aspects as children grow indicates that physical development is considered paramount for infants. Social/emotional development is uppermost for toddlers and runabouts. Cognitive aspects advance to be second in importance among runabouts.

Services received by children

Among those children currently enrolled:

1. Almost 2,000 have received general physical checkups, and more than 2,000 have received almost 8,000 immunizations (DPT and polio being most frequent).

2. More than 3,500 cases of treatment are reported. About 40% of those were emergency cases. Treatments for respiratory diseases and for simple anemia ranked next -- approximately 400 of each.

3. Only about half as many children have secured dental care as have received medical care. In all, 856 dental check-ups and approximately 400 each of cleanings and fillings were reported.

4 In all Centers but three, children receive at least one meal per day.

5. Finally, 95% of the CCR sample of mothers say they feel their children have learned something useful since joining the PCC.

   a. Mentions of social skill development and cognitive advancement (vocabulary, concepts) predominated -- about two-thirds reported those.

   b. Children's physical development and self-sufficiency (in dressing and personal hygiene) were each mentioned by approximately 40% of the mothers.

Staff data

In all, there are a total of approximately 700 professionals and non-professionals in PCC positions. That figure is about level with the one reported by KAI two years ago.

1. Although total number employed has not changed much over the last two years, the frequency of

various functional positions has. There are now considerably more Child Educators and Teacher Aides and slightly fewer social service, health, and administrative workers.

2. A clear majority of non-professionals have received at least two weeks of pre-service training. That training is most often highly detailed and presented somewhat didactically (as contrasted to an observational or practicum format).
3. Parents on staff show an educational attainment almost midway between non-parents on staff (who are better educated) and parents not on staff.
4. Non-professional staff members match the parents they serve fairly closely in most other demographic respects. The exception is ethnicity; more staff are Caucasian and more parents are Black.
5. Approximately two fifths of the professionals and four fifths of the non-professionals live within the catchment areas of the PCC's at which they are employed.
6. Staff turnover is high. More staff members have left PCC's than are now employed.
7. There is a particularly high turnover rate for Directors and for Nurses. Professionals have generally stayed at their jobs for shorter periods than non-professionals.

8. However, most of all those who leave the project do so for reasons of self-advancement. Their PCC training and experience has enabled them to obtain a better job.

INTRODUCTION

PURPOSE OF THE REPORT

The purpose of this report is to provide preliminary data on the impact of the national Parent-Child Center Program (PCC) to the Office of Child Development (OCD). The data relate to what can be termed an immediate criterion of impact -- a broad catalogue of what exists and is being done, not an evaluation of same. That is, the information in this document summarizes numbers of families served and types of services provided. For example, it might be stated that N number of children received nutritious meals. No statement will be (nor can be) made now that the nutritional status of those N participants has been improved by X degree as a result of the PCC program. Such evaluative interpretation must await the study's second phase, which will be an in-depth study of impact on families over the next 18 months. Moreover, this report includes none of the clustering analysis, which is to be documented separately.

BACKGROUND

Although "serving as a locus for research and evaluation" has been one of the six national PCC objectives, this particular function has been given the least direct attention by the PCC's. PCC staffs have been too busy providing service to become particularly concerned with ongoing program documentation. Where research has been performed, it

almost always has been initiated and performed by interested outside parties: university personnel or community professionals. From this, as might be expected, there has emerged no uniform body of information which is descriptive of the operations of the PCC's,or of the nature and scope of program impact. In fact, there exists nationally little objective data descriptive of the day-to-day PCC operation.

The one national study of the PCC's relevant to the current evaluation was completed over two years ago by Kirschner Associates Incoporated (KAI). While the KAI study was based upon extensive data collection activities, the study report was intended to be a descriptive evaluation of the first year of the project.

In addition to the wealth of data provided by the KAI study, KAI staff developed a national PCC data reporting system. For a variety of reasons, that system was not maintained, so that there is a dearth of available information.

The Center for Community Research (CCR) is to provide information relating primarily to the impact of PCC programs upon their participants. Phase I involves collection of information descriptive of individual PCC programs; those data are to be used mainly to identify different types of Centers. While CCR was to be responsible for a study of impact among the PCC's another firm (Abt Associates) is responsible for the Management Information System (MIS) which

will provide national OCD headquarters with the data necessary for managerial decisions. The MIS system will be in operation by July 1973; it must be pretested, refined and implemented, before the information will become regularly available. In the meantime, there is an urgent need for the types of information which the operating MIS system could be expected to provide; CCR, already in the field with the preliminary stages of the impact study, was requested to collect those additional data which would make possible an early, preliminary impact report as well as the Phase I report on program characteristics scheduled for March 1972.

Thus, the data presented in this preliminary report are no substitute for either the Phase I clustering report, or for the Phase II impact study, which is now scheduled for completion in June 1973.

METHOD OF PROCEDURE

The first phase of the CCR impact study involved the collection of descriptive data for clustering the major different types of PCC's. The data-gathering instruments developed for the collection of these clustering data were enlarged to include questions which would elicit preliminary impact data. Aside from the nature of the instruments, however, the procedures used in the collection of preliminary data were those planned for the collection of Phase I clustering data, so the information was obtained for both purposes from the same respondents during the same on-site interviews.

Who was interviewed?

Data were collected from both parents and staff members. It was originally planned to develop random samples of 50 percent of the staff at each Center, and 20 percent of parents. Attempts to implement truly random sampling procedures were abandoned, however, for several reasons. First, with regard to staff, it became evident that a completely random procedure would make possible the omission of key staff members. Instead, staff members were selected for sample inclusion on the basis of function served in the PCC, as a means to ensuring that all program components and all levels of staff within these components were represented in the data collection procedure. In PCC's having more than one staff member in a given function, random selection was made among those members. In brief, a stratified random technique was used. In PCC's with multiple sites, CCR staff visited nearly all sites in order to ensure staff representation across various geographic areas and within highly localized program variations.

True randomization of parent interviews also proved impractical, for logical as well as for tactical reasons. First of all,experience quickly showed that those parents who hardly ever came to the Centers (a reality in some locations) had virtually no idea of what went on at the Center, other than some vague understanding of what the formal goals of the Center might be. Thus, collection of data from such

respondents for clustering purposes would have served only to fulfill a priori sampling requirements. Conversely, those who came frequently to the Centers were most apt to be aware of what transpired. From the standpoint of feasibility, home visits to individuals who have little to do with the PCC, yet who are selected on a random basis, are not easily effected. Some home visits were made early in the study, and were found to require inordinate PCC and CCR staff time.

Particularly since these data are to be used in creating descriptions of the Centers, and for documenting the services provided, rather than for a comprehensive evaluation of impact among a representative sample of PCC members, the question of having a representative random sample is less important than that of obtaining a full picture of what is provided.

Moreover, to ensure representation across local program variations at multiple-site Centers, CCR staff interviewed parents and staff at nearly all PCC sites. Again, such information can best be obtained from those who are most familiar with the program, i.e., the regular participants.

Somewhat the same can be said of the sampling proportions. While in every case at least 50 percent of staff were interviewed, and while in most cases a 20 percent parent sample was developed, the opinion of CCR staff was that, for this preliminary phase of the study, the inclusion of 20 percent of parents in all of the Centers represented something of a waste.

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That is, two or three parent interviews usually sufficed to establish the pattern of services available. In terms of general reactions to the programs, major issues, etc., generally ten or a dozen interviews would have been adequate.

The sampling procedures actually used were as follows:

1. Staff members were selected on the basis of interviewer judgment (with central CCR office consultation in unclear cases) so as best to represent the variety of PCC job functions, levels of training and/or experience, and local program variations if there were separate sites within a single PCC grant.

2. Directors and other staff members were asked to arrange parent interviews with a representative group (in terms of time enrolled, PAC membership, etc.) Other parents were approached by CCR staff and asked for interviews, which were always granted.[1]

3. Parents who were staff members as well, and who were selected for interviewing were approached sometimes as staff, and sometimes as parents (there being two different questionnaires, one for each of

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[1] It may be speculated that staff selection of parents could induce some positive attitude bias in that favorably disposed parents might be chosen. Even direct random selection by CCR interviewers could be bias-prone because parents so chosen would be showing interest in the program by their mere presence at the Center. However, as mentioned on the previous page, that possible bias was not of major concern given the research objective (description).

these two groups). Forty-six dual-role parents were interviewed as parents, another 70 as staff members. More were interviewed as staff to obtain a more comprehensive picture of training provided for indigenous personnel.

INSTRUMENTS

Data were collected using structured interview schedules designed specifically for this project. Copies of these questionnaires are to be found in the appendix. In addition, certain schedules were developed to record program statistics made available at each PCC. Finally, a number of scales were constructed and used in the collection of attitudinal data. Three interview schedules were used, as follows:

1. Director form:

   Includes five sections dealing with PCC goals, staff organization, programs for children and parents, medical services, and social services, respectively. This comprehensive form required from five to eight hours to complete, if done personally with the Director. In many cases, it was possible to delegate certain portions of the task to other members of the staff, e.g., Nurse might assume responsibility for providing the required health statistics, the Social Worker would provide information for the social service section, etc.

2. Parent form:

Includes questions dealing with demographic data, nature of services received, role of parents in the Center, perceptions of Center program focus, and a series of open-end questions about Center impact - both on the parent and on the interviewee's child(ren). This instrument took approximately one half hour to complete, interviewer and parent working together.

3. Staff form:

Includes items concerning job description, the importance of several personal characteristics for "professional" job functions, the extent, type, and suitability of pre-service training for "non-professional" positions, and demographics. Staff members also were asked their perceptions of program focus and of the Director's leadership style. Staff interviews were conducted individually and required approximately 30 minutes each.

In addition to these three sets of forms, a financial data was developed; each PCC was asked to provide financial data about the major program components. That form was self-administered with accompanying detailed guidelines.

While interview schedules were tried out locally among those members of the staff who are social workers, prior to implementation, it was impossible to pre-test the questionnaire materials in the formal sense of the word for two reasons. First, there simply was not sufficient time. Second, any meaningful pre-test would have involved at least some of the PCC staff, who then would have been expected to complete a (revised) battery, for a second time.

However, every effort was made to ensure that problems of administration would be minimized, and that the instruments themselves facilitated the collection of all desired information. In addition to internal staff review, draft instruments were reviewed by the OCD Project Officer, by the OCD Program Coordinators, and by the Study review group. Suggestions made were incorporated into the final form of the instruments.

Interviewers were all experienced CCR personnel. Despite this, one week was devoted to participation in a training seminar, in which interview staff first were instructed in use of the forms, followed by a series of practicums, interviews being conducted by and with the interview trainees.

Data collection procedures:

Site visits were made during the 11-week period extending from October 27, 1971 to January 11, 1972. During this period, 33 PCC's were visited. Dalton, Georgia, and Summerville, Georgia (LaFayette) have been treated for purposes of data analysis as two separate centers. This distinction was made on the basis of our findings at these centers. Each Center employs a separate Director, and functions completely autonomously from the other.

Thus, data were collected at all PCC's, with the exception of Alaska.

Interviews were conducted by eight full-time CCR professional staff members, augmented by one Sociology doctoral student, whose work had been previously known to the CCR.

Individuals, or teams of interviewers,were assigned to PCC's for an average of four interviewer-days at each site. In several cases, only three days were necessary; in other cases more time was required than had been anticipated (eight days at one site). Twice, the time allotted was insufficient, and a one-day follow-up visit was necessary, in each case. Where gaps were found during data coding and tabulation being conducted on an ongoing basis by CCR research assistants, a telephone follow-up was made.

Parents and staff were interviewed individually, save for the focus and/or leadership ratings which, at a very few of the PCC's,were administered in groups. Where such a procedure was adopted, the CCR staff member moderated in order to answer questions and to inhibit collusion.

Interviews were completed with 33 Directors, 327 staff, and 385 parents. It is upon these data that the following report is based.

The report is organized into three major chapters dealing with, respectively, parents, children, and staff. Within each

of these chapters are sub-sections addressed to: 1) demographic characteristics, (2) activities and participation and (3) what members get out of participating, i.e., preliminary impact.

CHAPTER I

THE PARENTS OF THE PCC

INTRODUCTION

In this chapter will be presented the data descriptive of PCC parents: who they are, what they do at the PCC, and what they have derived from the PCC experience. The data from the Director's Questionnaire represent certain information about all PCC parents. The data from the individually conducted interviews with 385 parents are used to flesh out and enrich the information on all parents.

A. WHO ARE THE PCC PARENTS?

As was discussed in the introductory section, randomness of parent selection for interviewing was neither feasible nor desirable. In the course of interviewing,CCR staff was aware that parents interviewed were perhaps the more articulate, involved participants. The sample obtained tends to be more involved with PCC than is the case among all parents. For instance, 42% of the parents interviewed are members of their Centers' Policy Advisory Council. However, the following points are relevant:

1. Non-random selection is a two-edged sword. While it is doubtless true that the articulate and the involved are over-represented, selection was not restricted to those who had only good things to say.

2. The mere fact that there were stories available for the telling, and people eager to tell them, is a finding. True, results may be weighted toward more positive feelings, but one can hardly ignore their presence.

Certain basic demographic information was collected from the parent sample. These data include: sex, age, education, ethnicity, marital status, and number and ages of children. Data regarding ethnicity are available on all PCC families.

Sex

The overwhelming majority (98%) of the 385 parents interviewed were mothers; fathers are under-represented in the sample. However, there is no reason to assume that this lack of father interviews biases this phase of the study, as the kinds of preliminary impact data collected, e.g., medical care, should not be biased by sex of the respondent. That is, the data document the services provided to PCC families; whether these data are provided by the mother or by the father should, for the most part, make little difference.

Age

In Table 1, below, are presented the data on the ages of the interviewees.

Table 1. Ages of parent sample.

Under 21	41 (11%)[1]
21-30	228 (59)
31-40	95 (25)
41 and over	20 (5)
No answer	1 (*)[1]
Base:	385

The majority of the mothers interviewed are between the ages 21 and 30. A small percentage of respondents are in their teens, and a high proportion of the sample is between 31 and 40. If our sample is representative of the PCC parent population as a whole, these data suggest that the typical PCC mother is not a young girl in her teens. Rather, the typical PCC mother is most likely to be in her twenties and one out of every four is in her thirties.

Education

The educational background of CCR respondents is presented in Table 2, below.

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[1] Numbers in parentheses throughout this report are percentages. Percentages for some tables will not sum to exactly 100 because of rounding. An asterisk (*) denotes less than 0.5%.

Table 2. Formal education of parent sample.

	TOTAL SAMPLE	LOCALE	
		Urban	Rural
9 years or fewer	105 (27%)	42 (17%)	63 (46%)
10-11 years	135 (35)	100 (40)	35 (26)
Completed high school	101 (26)	75 (30)	26 (19)
Some (all) college	40 (10)	29 (12)	11 (8)
Bus./Tech. school	2 (1)	1 (*)	1 (1)
No Answer	2 (1)	2 (1)	- -
Base:	385	249	136

The majority of the mothers interviewed had either some high school or had completed high school. A higher proportion of mothers in the rural Centers have not completed high school than is the case in the urban Centers.

Intact families

In Table 3, below, are presented the number of intact families and the number of single parent families.

Table 3. Number of intact families in parent sample.

	TOTAL SAMPLE	LOCALE	
		Urban	Rural
Children's father present at home	177 (46%)	81 (33%)	96 (71%)
Father not at home	152 (39)	118 (47)	34 (25)
No Answer	56 (15)	50 (20)	6 (4)
Base:	385	249	136

In the total sample, the number of homes in which the father is present is slightly greater than the number of families in which the father is absent. This relatively high rate of overall PCC father presence is accounted for by the relatively high proportion of intact families reported rurally. Nearly three out of every four rural families are intact, while only one out of every three urban families reports a father in the home.[1]

Ethnic background

The ethnic background of the entire PCC population and of the parent sample are presented in Tables 4a and b, respectively.

Table 4a. Ethnic background of total PCC population.

	TOTAL SAMPLE	LOCALE	
		Urban	Rural
Mexican-American	(8%)	(3%)	(18%)
Indian	(3)	(1)	(10)
Puerto-Rican	(4)	(6)	-
Black	(55)	(73)	(14)
Other Caucasian	(26)	(12)	(57)
Oriental	(3)	(5)	-
Other	(1)	(1)	(*)
Total	(100)	(100)	(100)

1. It is possible, though, that the true urban figure is somewhat higher. Fathers may be reported absent to maintain public assistance in some cases.

Table 4b. Ethnic background of parent sample.

	TOTAL SAMPLE	LOCALE	
		Urban	Rural
Mexican-American	31 (8%)	7 (3%)	24 (18%)
Indian	25 (7)	- -	25 (18)
Puerto-Rican	17 (4)	17 (7)	- -
Black	208 (54)	194 (78)	14 (10)
Other Caucasian	95 (25)	22 (9)	73 (54)
Oriental	9 (2)	9 (4)	- -
Base:	385	249	136

As can be seen from Table 4b, the majority of the respondents are Black. This is particularly the case in the urban PCC's where 78% of the mothers interviewed were Black. Caucasian respondents account for the majority in the rural centers. About one-sixth of the respondents in rural areas are of Indian origin, another sixth of Mexican ancestry.

Family size

Each respondent in the parent sample was asked the number of children and the ages of all children in the family. These data are presented in Table 5, below.

Table 5. Number and ages of children in parent sample.

AGES	CHILDREN[1]	CHILDREN[2]
Under six months	78 (20%)	78 (6%)
6-12 months	76 (20)	76 (6)
1-2 years	165 (43)	165 (12)
2-3 years	177 (46)	177 (13)
3-5 years	262 (68)	262 (19)
5-8 years	225 (58)	225 (17)
8-11 years	174 (45)	174 (13)
11-14 YEARS	99 (26)	99 (7)
14+ years	91 (24)	91 (7)
Base:	385	1347

The data in Table 5 support the data presented in Table 1 regarding the relatively older age of the respondents. As can be seen from Table 5, a very high proportion of mothers interviewed have children who are 3-11, and about one out of four mothers has a child who is older. Children under

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1 Percentages are proportions of parent base, and sum to more than 100.

2 Percentages are proportions of all children in parent sample.

one year of age are present in about one out of two families. The mean number of children per family (35) suggests that the typical PCC family, as represented in the sample, has three or four children. Based on the mother's age, the number of children per family, and the age distribution of the children it seems evident that the PCC focal children are generally not first born children. In other words, the majority of PCC children have several older siblings.

Focal children

Even within the ages served by PCC, not every eligible child in a family is enrolled in PCC. Presented below in Table 6 are the data pertaining to the ages of focal children enrolled.

Table 6. Focal children by age.

AGES	FOCAL[1] CHILDREN	FOCAL[2] CHILDREN
Under six months	49 (13%)	49 (9%)
6-12 months	71 (18)	71 (13)
1-2 years	161 (42)	161 (28)
2-3 years	160 (42)	160 (28)
3-5 years	124 (32)	124 (22)
Base: Total:	385	565

[1] Percentages are proportions of parent base, and sum to more than 100.

[2] Percentages are proportions of all children in parent sample.

Relatively few of the respondents have infants. The majority have focal children who are between one and three. A high proportion of children served are between the ages of three and five. This is particularly true in rural areas, where the greater scarcity of Head Start programs or of Head Start programs which accept four-year-olds puts the PCC in a position where it must continue to provide service. In many of the Centers strong resentment was expressed against a policy which would provide services to children until age three, and then leave the children stranded with no program until age five. In any event, it is noteworthy that one out of every three focal children served is between the ages of three and five. The mean number of focal children in each family (1.5) suggests that a large minority of families have more than one child enrolled in PCC.

Thus, the typical PCC child has three other siblings, one of which is likely also to be enrolled at the PCC. In addition, children enrolled in PCC have mothers who are also members and in 12% of the families the fathers are also members.

Table 7. Members other than focal children and siblings served by PCC.

	AMONG TOTAL SAMPLE	LOCALE	
		Urban	Rural
Mothers of focal children	384 (83%)	250 (87%)	134 (75%)
Fathers of focal children	56 (12)	16 (6)	40 (22)
Siblings of mother or father	4 (1)	4 (1)	- -
Other (grandparent, non-relatives	21 (5)	17 (6)	4 (2)
Total	465	287	178

As might be expected, particularly as a function of the larger number of intact families in rural areas, there is a greater proportion of fathers participating in the rural programs. It is interesting to compare these data with the data presented in Table 3 on the number of intact families. In the total sample, out of 177 fathers present in the home, 56 are members of PCC. In other words, approximately one third of the available fathers are PCC members.

Summary of CCR parent data

In summary the following points can be made about the CCR parent sample:

1. Virtually all of the respondents were mothers.
2. The average mother in the sample is in her twenties, and one out of every four is in her thirties. There are relatively few teenage mothers in the sample.
3. Twenty-seven percent of the mothers in the CCR sample has had nine or fewer years of education. One out of three mothers has had some high school, and 26% completed high school.
4. The father is present in the home in almost three out of four rural families and in one out of three urban families, although the true urban figure might be higher due to deliberate reports of father absence.

5. In the CCR sample, the vast majority of urban respondents are Black and the majority of rural respondents are Caucasian.
6. The average family in the sample has three or four children. The focal PCC child generally has several older siblings. One-quarter of focal children's older siblings are 11 or older.
7. The majority of focal children in the CCR sample are between the ages of one and three. Thirty-two percent of focal children are age three to five, and relatively few focal children are infants under the age of one.
8. PCC families in the sample have an average of 1.5 focal children enrolled. In addition, in the vast majority of families the mother is also enrolled. Approximately one third of the available fathers are also enrolled in PCC.

Comparison of KAI and CCR Data

A comparison of KAI data collected between September 1968 and September 1969 and CCR data collected between October 1971 and January 1972 shows a marked similarity in all areas. Essentially, data from the CCR sample matches KAI data in all

of the following: age and education of mother, family composition, ethnic proportions, and number of focal children per family. In some instances the data are virtually identical. KAI reported 3.6 children per family, CCR found 3.5 children. KAI[1] reported 1.4 focal children per family, and CCR found 1.5 such children.

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1. It should be pointed out that all KAI data came from PCC summary records or direct observation of all Center participants. They are not sample data. Comparison of KAI population figures with CCR sample results may naturally involve some statistical error, yet it is still interesting to see how well values match -- then and now.

   When data not from the CCR sample (i.e., PCC summary records) are reported, the comparison with KAI is direct -- population vs. population.

B. WHAT DO PARENTS DO AT THE PCC?

In this section we present those aspects of the data which have bearing on impact: what it is that parents do at the PCC, in what kinds of programs they participate. Some of these data were obtained from our sample of 385 parents; other data were obtained from the Director or from staff designated by the Director to provide program information.

In Table 8, below, are presented the data on length of membership among our sample of respondents.

Table 8. Length of time a PCC member, parent sample.

LENGTH OF ENROLLMENT	TOTAL SAMPLE	LOCALE	
		Urban	Rural
Less than 3 mos.	30 (8%)	24 (10%)	6 (4%)
3-6 months	50 (13)	38 (15)	12 (9)
6 mos.-1 year	53 (14)	35 (14)	18 (13)
1- 1-1/2 years	61 (16)	43 (17)	18 (13)
1-1/2 - 2 years	47 (12)	30 (12)	17 (13)
2 - 2-1/2 years	59 (15)	36 (14)	23 (17)
Over 2-1/2 years	82 (21)	41 (16)	41 (30)
No Answer	3 (1)	2 (1)	1 (1)
Base:	385	249	136

The average respondent in the parent sample has been a PCC member for one and one half years. There is a marked tendency for rural members of our sample to have been members for longer than the urban members(21 months for rural versus 17 months for urban, respectively). This is likely to be a function of greater geographic mobility among an urban population and of the fact that the rural Centers tend to serve children up to higher ages. In any event, based on our sample, there seems to be relatively little turnover of program participants. The vast majority of our respondents have been PCC members for more than one year. Since data were not collected on the length of enrollment for the entire PCC membership, there is no way of knowing whether the one-and-one-half-years average enrollment of the CCR sample is representative or not. In terms of the objectives of Phase I of the study, i.e., to describe the Centers and what they offer, representativeness along this dimension is not considered to be of importance.

Education component

Thirty of the Centers have an adult education component. At most Centers the various parent education activities are part of an ongoing year-long course. Topics are not covered consecutively for fixed time periods. Rather, the subject matter shifts from session to session to suit the needs or desires of parents. Consumer education, for example, might be discussed at two consecutive meetings, or it might get only 15 minutes of attention one day and be returned to weeks later.

Different topics are covered by staff members who only occasionally are specialists in the areas covered. Parent Educators cannot be specialists in the multiplicity of topics which they teach, e.g., child development, nutrition, sewing, career development, and consumer education. Because of this complexity, CCR could not ascertain the specific specialties of each Parent Educator. Therefore, it is impossible to state in the discussion which follows in how many Centers the topic taught is covered by a specialist in that field. In Table 9, below, are presented the data on the variety of parent activities available to all PCC parents.

Table 9. Parent education activities for total PCC membership.

CLASS	NO. OF CENTERS WHO REPORT OFFERING
Child development	28 (85%)
Home management	
Nutrition	20 (91%)
Menu planning	25 (76)
Cooking	27 (82)
Sewing	28 (85)
Consumer education	27 (82)
Purchasing clothing	18 (55)
Budgeting	22 (67)
Home repair	14 (42)
Housecleaning	6 (18)

(continued)

Table 9. (continued)

CLASS	NO. OF CENTERS WHO REPORT OFFERING
Health	
Health/first aid/ hygiene	24 (73%)
Birth control	21 (64)
Career development	
Child care career	15 (45)
All other skills/ trades	7 (21)
Arts/crafts/hobbies	12 (36)
Basic adult education	11 (33)
Personal appearance	4 (12)
Other	4 (12)
Base:	132

Note: Multiple responses occurred.

It is difficult to offer a description of the educational styles followed. PCC's vary widely in the formality or informality with which teaching is done. Most parent education is not formal in a classroom type of setting. Rather, it usually involves open discussion of issues or problems of interest to parents in a given topic area. Distinctions of teaching style are blurred. It is impossible to report how many PCC's teach a given topic in any specific manner.

Twenty-eight of the PCC's offer parents some education in early childhood. In some Centers this education is largely didactic, in others it involves some didactic education and/or some observation of what staff does with children, and in still others it involves some didactic education and/or some observation of staff, and/or some actual participation in the process for a few hours a week. Some Centers require that each mother spend a certain amount of time with her child in program, others do not.

A very large majority of PCC's offer some education in activities related to home management. Nutrition, menu planning and cooking are all part of a constellation of activities. In some Centers this constellation is called "cooking," in others "nutrition," etc., but the basic activity is the same. Either an actual meal is cooked and discussed from a nutrition viewpoint, or the values of different foods and the planning of menus are discussed. Consumer education, budgeting, and shopping represent another important cluster of home management related activities. In some Centers this is done through actual group shopping trips which are followed by discussion. Sewing classes are another very common activity offered at the great majority of PCC's. Home repair as a course is offered by slightly fewer than half the Centers.

Health education is offered at almost three out of four of the Centers. Generally, health education is provided either on an individual basis as each mother brings her children in for

routine physical exams or for treatment, or on a group basis. At most Centers, birth control information seems to be covered on a more individual basis.

Basic adult education is offered at one out of three Centers, through the PCC. In these Centers there is an emphasis on helping parents to obtain their General Equivalency Diplomas.

Career development is a focus of nearly half the Centers. The majority of those which do have a career development focus emphasize careers in early childhood rather than in other areas.

Center Directors were asked to rank in order of importance the major categories of PCC parent education activities. These data are presented in Table 10, below.

Table 10. Importance ranks of parent educational program components by Directors.

	CHILD DEVELOP.	HOME MANAGEMENT	HEALTH EDUCATION	CAREER OPPOR.	BASIC ADULT ED.
Most Important	22 (67%)	4 (12%)	5 (15%)	2 (6%)	- -
Second	4 (12)	16 (49)	10 (30)	- -	2 (6)
Third	4 (12)	8 (24)	12 (36)	1 (3)	6 (18)
Fourth	2 (6)	2 (6)	4 (12)	7 (21)	13 (39)
Least Important	- -	2 (6)	- -	18 (55)	8 (24)
No Answer	1 (3)	1 (3)	2 (6)	5 (15)	4 (12)
Base:	33	33	33	33	33

Sixty-seven percent of the PCC Directors feel that child development is the most important aspect of parent education. Education related to the home is considered by the majority of directors to be of either first or second rank importance. Health education is considered by most Directors to be of second or third rank importance. Basic adult education appears to be in fourth place, and career opportunities are felt by a majority of directors to be least important. Thus, the modal PCC Director would stress child development the most, then home management, and then health education. Basic adult education and career opportunities would receive a decidely lower priority.[1]

Twenty-two of the PCC's have programs for adults which involve some education, in most of the above areas, at the Center itself. Three Centers have a parent education program which is mostly home based, and in eight Centers the location of the adult program is almost evenly divided between Center and home.

In 15 Centers, education is carried out primarily in groups and in three Centers it is done mostly among individuals. In 15 Centers some education is done on an individual basis and some is done on a group basis.

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[1] In retrospect, CCR regrets that parents were not asked to rate the importance of program components. In summary statements about visits made, interviewers noted that career opportunities were considered rather important by parents at some PCC's.

In three out of four Centers there is no time limit on the duration of a class, i.e., there is no fixed period of time for which a particular topic is taught or discussed. Rather, most topics are discussed on an ongoing basis as part of an overall emphasis on adult education.

Fifteen PCC's have developed college affiliations. Twelve have parents attending classes as part-time students and three have at least some full-time students. Nine of the 15 programs have an eligibility requirement for college entrance: high school diploma or special exam. In seven out of the nine cases, it is the college and not the PCC which sets the requirements.

Fifteen of the affiliated colleges offer courses in child development, eight in social services, seven in English, and seven in home economics. Other courses, e.g., business and various arts and crafts are offered by three or four colleges.

Social service component

PCC's offer their membership different types of social service. Eighteen Centers have a social service department to which parents turn when they need a specific service. Four Centers assign families to a social work aide who sees those families on a fairly regular basis, usually in the home. This latter pattern of service derives from a clinical model in which the PCC families are seen as social work cases and each worker

has her case load. Remaining PCC's handle social service less formally, with any staff members discussing individual parent problems as they arise and making referrals when necessary.

Tables 11a and 11b show the variety of social and counseling services offered and the number of PCC's which offer each kind.

Table 11a. Number of PCC's providing various aspects of a social service component.

	EMERGENCY ASSISTANCE	TRANS-PORTATION	JOB COUNSELING
PCC provides service	19	32	9
PCC refers service	9	-	23
Not provided	5	1	1
Base:	33	33	33

Table 11b. Number of PCC's providing various kinds of counseling services.

	INDIVIDUAL	MARITAL	GROUP
Informal, by PCC	6	7	9
Formal, by PCC	11	10	10
Referral	14	12	5
Not provided	2	4	9
Base:	33	33	33

Transportation is provided by 32 Centers. PCC transportation is used to take members for medical appointments, to other agency appointments, for shopping expeditions, and in most Centers to bring members to the Center.

Nineteen Centers have an emergency fund which is used to give temporary relief to families under extreme financial pressure.

Job counseling is provided by nine PCC's; the majority of Centers make referrals.

Almost one out of three PCC's provides individual, marital, and group counseling on a formal basis. In the Centers, there is a trained professional either on the full-time staff, or on a consultant basis, who has specific and often ongoing appointments with parents.

Informal counseling is conducted at a number of PCC's. This generally means that parents either should or do feel welcome to stop and chat with staff about anything which is bothering them. In these Centers a friendly supportive atmosphere, along with the provision of a sounding board, is the approach to emotional and interpersonal problems.

A substantial number of Centers have no counseling service. Particularly in the area of individual and marital counseling, most of these Centers rely on referral to other agencies. Group counseling is not provided by or through nine Centers.

Table 12, below, shows the number of agencies with which PCC's maintain relationships. Most of these are agencies to which Centers refer members for various services. Nine of the PCC's have a list of agencies which they either give to participants or to which staff refers when the need arises.

Table 12. Agencies to which PCC's relate.

	NO. OF PCC's
I. MEDICAL INSTITUTIONS	
Local health department	25
Hospital	21
Neighborhood health center	20
Other medical organizations	18
Maternal/child health center	13
Veterans Administration	12
Visiting Nurse Association	9
Medical society	7
II. EDUCATIONAL INSTITUTIONS	
Head Start	26
Elementary schools	21
Higher education institutes	21
Secondary schools	13
Private schools	7
III. COMMUNITY AGENCIES	
Religious organization	23
Community Action Program	21
Child care center	21
Neighborhood service program	18
Philanthropic organization	6
IV. SOCIAL AGENCIES	
Psychological service	24
Other social service/counseling	18
V. PUBLIC AGENCIES	
Welfare department	31
Employment office	19
Other public department	14
VI. BUSINESS, CIVIC, AND LEGAL ORGANIZATIONS	
Legal Aid Society	21
Bar Association	3
Other legal organization	7
Business organization	12
Civic organization	8
Labor organization	7
Base	50 / 33

It is readily apparent that most Centers do have a social service component, and that collaboration has been established with many community agencies. It should be noted that in the above table only those listings were counted in which the specific person typically contacted could be supplied. Thus, all of the above represent at least some minimal level of actual cooperation. The majority of Centers do seem to serve as a coordinating mechanism for their membership.

Summary

In summary the following points can be made about what parents do at the PCC and about certain aspects of their membership:

1. The average parent in the CCR sample has been a PCC member for one and one half years.
2. PCC members engage primarily in the following educational activities, as reported by Directors and program staffs: child development; home management, e.g., nutrition and cooking, consumer education and budgeting, sewing; health education; adult education; and career development.
3. Fifteen Centers maintain affiliations with colleges, at which courses in child development, social services, English, and home economics are offered.

4. All PCC's have some social service component. Centers either provide or refer for a wide variety of social and counseling services. In addition, the majority of PCC's have established a cooperative relationship with a large number of agencies in the community.

Comparison of KAI with CCR data

Although some of the PCC's now in operation were not two years ago, others have replaced them; KAI and CCR have both obtained data from 33 Centers. Thus, direct comparisons of numbers of PCC's providing various services or programs can be made. In comparison with KAI's findings of two years ago, the present survey shows that:

... Child development education availability has increased sharply. Twenty-eight Centers offer education in this area now; only 16 did two years ago.

... Home management education is now given at virtually every PCC. Every topic area shows more PCC's offering now than two years ago. Some examples: nutrition (30 PCC's now versus 12 two years ago); sewing (28 now versus 23); consumer education (27 now versus 11); home repair (14 now versus 8).

... Job training for child care careers has expanded from six PCC's to 15 now.

... Adult basic education provided directly by PCC's has stayed level -- 11 Centers.

It is harder to draw parallels in social service areas, because data were not obtained in similar manner. However, some comparisons are possible:

... Nine Centers now offer job counseling, as against six before.

... Emergency funds or materials are now available at 19 Centers, more than double the nine that offered those two years ago.

... Transportation to services is now offered by all but one PCC; three lacked that provision before.

... Ten PCC's themselves offer formal counseling in at least one of three key areas: Individual, marital, or group. KAI did not break this out specifically in their report, but textual allusions make it appear certain that this function has developed considerably in the interim.

In overview, CCR data show a marked increase in PCC services to families. As will be seen subsequently, that increase is indeed associated with a clear increase in number of participants served, too.

C. WHAT HAS HAPPENED AS A RESULT OF PCC MEMBERSHIP?

What parents do at, and through, the PCC has been described. The question can now be raised as to what impact can be reported at present as a function of this participation in PCC events and activities. Once again, it must be remembered that this is a report on preliminary impact data.

Two kinds of preliminary impact data are reported: 1) objective data on the numbers of parents who report, or who have been reported as having received specific kinds of services or referrals, which in and of themselves can be assumed to be of benefit: e.g., medical services, dental care, job placement, etc. 2) subjective reports of parents on what they feel they have gained from PCC membership.

Each of these kinds of data will be presented below.

1. OBJECTIVE MEASURES OF IMPACT

a. Health Component

In Table 13 below are presented the data from our parent sample on whether or not the Center has done something specifically for their health.

Table 13. Number of adult respondents who report receiving medical services for themselves.

	TOTAL SAMPLE	LOCALE	
		Urban	Rural
Received medical care	182 (47%)	98 (39%)	84 (62%)
Did not receive	196 (51)	145 (58)	51 (37)
No answer	7 (2)	6 (3)	1 (1)
Base	385	249	136

Approximately one half, or 182, of the respondents report receiving some kind of medical services as a function of their PCC membership. The proportion of respondents reporting such care is considerably higher[1] in rural than in urban areas. CCR's findings agree with KAI that "the successful efforts of many of the rural Centers to develop and coordinate medical resources for the PCC families are impressive."[2] Rural parents themselves mentioned this aspect more frequently than their urban counterparts when describing in their own words what PCC membership has meant to them (see Table 27 on page 56).

A note on terminology in the following discussion: a PCC may perform three different functions in the medical area.

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1 Chi-square of 16.7 with one degree of freedom (omitting non-response). A value of 10.8 is required to demonstrate contingency at the .001 level of significance.

2 A national survey of the Parent-Child Center program (1970), p. 302.

One is direct medical service -- usually fist aid or the administration of proprietary medications such as aspirin -- at the Center. Virtually every PCC does that. Second is coordination of service -- making appointments, transportation to same, and any required follow-up (including record keeping). Most Centers do that, too. Finally, there is securing medical care -- actually starting a service in the community, or at least making an already existent one available to enrolled families. Relatively few PCC's have done that. It is impossible to say exactly how many; doing so involves interpretation of terms. However, in the discussion that follows, the word "secured" will be used as a compromise among "gave directly," "provided" (which implies that), or "coordinated." CCR's feeling is that participants do not make such fine distinctions. With respect to impact, they tend simply to perceive whether a service is there or not, not how it came about or any arbitrary typology of it.

At each Center, the PCC Nurse or the health agency affiliate was asked to fill out a questionnaire dealing with the medical services secured for parents during the course of the past year. Reports are available from 30 PCC's on medical care. Of those 30 Centers, 25 state that they secure some sort of medical services to parents. Data on the number of adults receiving check-ups, tests, or immunizations are presented in Table 14.

Table 14. Numbers and kinds of checkups/tests and immunizations given to PCC total parent population.

SERVICE	NO. PCC's SERVING ADULTS	NO. ADULTS SERVED
CHECKUPS/TESTS		
Physical	16	587
X-ray[1]	14	345
Vision[1]	10	318
Hearing[1]	8	271
TB[1]	11	448
Simple anemia[1]	9	271
Sickle cell anemia[1]	3	18
Lead poisoning[1]	2	15
IMMUNIZATIONS		
Polio	5	134
Smallpox	5	108
DPT	3	101
Measles	-	-
German measles	-	-
Mumps	-	-

The treatments for medical illnesses secured for parents are presented in Table 15, below.

[1] Numbers reported for these checkups refer to instances when these are not part of a general physical examination.

Table 15. Number and kind of medical treatments: total PCC parent population.

SERVICE	NO. PCC's TREATING ADULTS	NO. ADULTS TREATED
Emergency	9	634
Sickle cell anemia	4	21
Simple anemia	6	34
Lead poisoning	-	-
Malnutrition	1	1
Heart disease	5	6
Respiratory disease	8	81
Back problems	7	11
Tuberculosis	2	4
Corrective operations	8	34
Skin diseases	4	14
Vitamins	6	63

The parent sample was asked to report whether or not they had received any dental care as a function of their membership in PCC.

Table 16. Number of adult respondents who report receiving dental services for themselves.

	TOTAL SAMPLE	LOCALE	
		Urban	Rural
Received dental care	90 (23%)	38 (15%)	52 (39%)
Did not receive	281 (73)	205 (82)	76 (56)
No answer	15 (4)	6 (3)	8 (6)
Base:	385	249	136

As can be seen from Table 16, one out of every four respondents reports receiving some dental services for herself. As was the case with medical services, it is clear that a relatively higher proportion of dental services are received by parents in rural PCC's. In the parent sample, 22 parents report receiving false teeth, 39 report extractions, 41 report fillings, and 42 report cleanings.

Twenty-one Centers report that they secure dental services to parents. Each of these Centers was asked to provide data on the number and kind of dental interventions secured for PCC adult members during the past year. These data are presented in Table 17, below.

Table 17. Number and kind of dental treatment reported given to PCC total parent population.

SERVICE	NO. OF PCC's TREATING ADULTS	NO. ADULTS SERVED
Checkup	14	389
Cleanings	13	297
Fillings	13	281
Extractions	15	262
Peridontal work	8	122
Fluoride treatments	6	119
False teeth	10	77

b. Education component

Below are presented the numbers of currently enrolled PCC mothers and fathers who have participated in the various PCC education programs and activities during the past year.

Table 18. Number of mothers and fathers participating in PCC educational programs.

CLASS	TOTAL NO. MOTHERS	TOTAL NO. FATHERS
Child development	1,145	126
Home management		
Nutrition	1,062	19
Menu planning	928	5
Cooking	986	5
Sewing	919	5
Consumer education	965	28
Purchasing clothing	786	17
Budgeting	872	81
Home repair	445	122
Housecleaning	285	15
Health		
Health/first aid/hygiene	992	72
Family planning	963	60
Career development		
Child care career	311	16
All other skills/trades	95	46
Arts/crafts/hobbies	60	-
Basic adult education	105	16
Personal appearance	441	6
Other	76	3

The table enumerates 121 parents currently receiving basic adult education. Eleven PCC's offer such courses, and these report an

average of ten GED's obtained by parents currently enrolled. Since the number of Centers affording basic education has not changed since the KAI study two years ago, it may be inferred that PCC is producing a relatively steady flow of parents who are earning high school equivalencies.

Nationwide there are currently 1,799 mothers,512 fathers, and 332 other family members involved in all educational activities. Thus, there are 2643 adults involved in these programs. There is no way of assessing objectively at present just what the "true" impact of these activities is on the parents involved, but it can be said that on the average eighty low-income parents are receiving education in certain critical areas at each PCC. Moreover, as will be discussed further on in this report, parents themselves feel that they are learning a great deal.

As stated earlier 15 PCC's have college affiliations. In those 15 PCC's, a total of 157 current parents have either completed their college work or are presently enrolled. Thirty-five parents have dropped out of college. Table 19, below, shows the number of parents who are currently enrolled or who have finished their course work.

Table 19. Number of parents in college studies (Directors' report).

	MOTHERS		FATHERS	
	Full-time Students	Part-time Students	Full-time Students	Part-time Students
Completed curriculum	1	26	-	3
In-process	12	88	6	21
Total	13	114	6	24

Of those 30 who have completed curricula, 14 received associate or vocational degrees, eight received completion certificates or something similar, the remainder received nothing.

c. Social service component

The parent sample was asked to report whether the PCC had given them any material help and if so to describe the kind of help given. These data are presented in Table 20, below.

Table 20. Material help reported by parent sample.

	TOTAL SAMPLE
Food stamps	28 (38%)
Find housing	13 (17)
Provide clothing or things for home	36 (45)
Total	77

Note: Base is those reporting material aid.

Out of the total 385 parents interviewed, relatively few report receipt of specific material services. Thirty-six mothers say they have received clothing and things for the home, 28 report receiving food stamps, and 13 report that the PCC helped them to find new housing.

In Table 21, below, are presented the number of referrals to various agencies discussed by the CCR sample of parent respondents.

Table 21. Referrals to other agencies, based on those reporting referral.

	TOTAL SAMPLE
Legal aid or police	33 (25%)
Welfare	24 (18)
Social service agency	90 (68)
Head Start	15 (11)
Day care	10 (8)
Housing Authority	12 (9)
Total:	184
Base:	133

Note: Multiple responses occurred, percentaged to base.

Each Center was asked for data on the number of referrals to other agencies and the number of referrals from other agencies. These data are presented in Table 22. They cover the last year.

Table 22. Number of referrals to and from other agencies for the entire PCC membership.

	REFERRALS TO	REFERRALS FROM
Medical/health organization	2,026	262
Social service/counseling	1,454	583
Educational institution	337	204
Religious/philanthropic organization	30	5
Public departments	2,406	719
Business/labor/civic organizations	499	72

These referrals represent impact at the immediate criterion level. Without further study it is impossible to tell to what degree the lives of people actually improved as a result of these referrals to and from PCC. Nevertheless it can be assumed that in the case of such large numbers of referrals to health organizations, to social service organizations, to government departments, and to other community agencies there has to be some impact on families.

In Table 23 are the number of respondents who report having been on welfare before joining PCC and the number on welfare at the time of the study.

Table 23. Number of parent respondents who report being on welfare prior to PCC membership and at the time of the study.

	PRIOR TO PCC MEMBERSHIP	AT PRESENT TIME
Receiving welfare	177 (46%)	190 (49%)
Not receiving	155 (40)	154 (40)
No answer	53 (14)	41 (11)
Base:	385	385

These data suggest that the actual number of people of welfare has remained relatively stable over time.

In Table 24 are the number of respondents who report a job for a family member before joining PCC and the number who report jobs at the time of the study.

Table 24. Number of parent respondents who report someone in the family having jobs prior to PCC membership and at the time of the study.

	PRIOR TO PCC MEMBERSHIP	AT PRESENT TIME
Employed	223 (58%)	234 (61%)
Unemployed	162 (42)	151 (39)
Base:	385	385

The data in both Tables 23 and 24 do not account for individual changes and movement. Additional inspection of data not represented in the tables show that there are in our sample 147 individuals who were on welfare prior to PCC and who have remained on welfare; there are also 123 individuals who were not on welfare prior to PCC who continue not to be on welfare. Thus, there are 270 individuals whose status vis-a-vis welfare has not changed. As Table 23 indicates, there are no data on 53 of the remaining 115 respondents. Thus, there are 62 individuals whose welfare status has changed. Of these, 26 were on welfare originally, but are no longer on welfare and 32 were not on welfare originally but are on welfare now. As several parents indicated, PCC has performed a service to some by helping them obtain welfare. A few parents who are entitled to public assistance and who needed it were either unaware or unable to be enrolled.

Similarly, with respect to jobs, there are 178 families in which some member had a job, prior to PCC membership and continues to have a job; there are 105 families in which no one had a job

prior to PCC and in which no one has a job now. Thus, there are 283 families in which there has been no change. Among the remaining 102 families, 14 gave no answer, 39 included a working member prior to PCC but currently no one has a job; 49 families were jobless prior to PCC, but currently a family member is employed.

In the families where jobs held previously are no longer held, this seems to be primarily a function of pregnancy and motherhood. In other words, a number of respondents indicated that they were working, got into the PCC when they became pregnant, and simultaneously gave up their jobs.

Parents were asked a number of questions about their subjective feelings of internal change, but one objective measure of change which was sought was an answer to the question of whether or not PCC parents had become interested in any outside community groups or boards since they joined PCC.

Table 25a. Participation in community groups and on local boards since joining the PCC.

	TOTAL SAMPLE
Participate in community groups	102 (26%)
Do not participate	263 (68)
No answer	20 (6)
Base:	385

Table 25b. Nature of participation.

	TOTAL SAMPLE
Social groups	18 (18%)
Education	61 (60)
Political activity groups	12 (12)
Community boards	35 (34)
Other	20 (20)
Total:	146
Base:	102

Note: Multiple responses occurred, percentaged to base.

About one of every four parents has joined some community group or become involved in some activity since joining the PCC. Among the 102 respondents who report such activities, 61% report involvement in educational activities. These generally mean membership in the local PTA, or on the local Head Start board. Thirty-five mothers report membership on various community boards.

Summary of Parent Services

With regard to medical, dental, educational, and public services obtained while members of Parent-Child Centers, the following points have been established:

1. Almost half (47%) of all participants have secured medical aid, with rural members (62%) being more likely recipients than urban (39%).
2. Half as many (23%) have obtained dental care, the division again favoring rural (39%) over urban (15%).
3. Enrollment in PCC-provided educational curricula is considerable, involving 512 fathers along with 1,799 mothers. Home management accounts for the greater part of participation, but more than 900 are exposed to family planning, 327 are gaining education directed at child care careers, and 121 are taking basic adult certificate courses.
4. One hundred fifty-seven are taking college courses; 30 current parents have already completed their schedules, with 14 of these receiving associate or vocational degrees.
5. Centers have made more than 6,000 referrals to community agencies (for all reasons) during the past year.
6. Slightly more enrolled families are receiving welfare help than they were before joining PCC, and slightly more have a member employed. Centers have facilitated economic support in both ways.

7. Finally, among the parents sampled, a fourth are participating with community groups or boards. Much of that participation concerns educational groups, mainly PTA's.

Comparison of KAI with CCR data

The only point of direct comparison between the studies in this parent-oriented section involves educational participation:[1]

> ... Involvement with PCC courses has risen more than 200%. For example, 1,081 parents are now reported in nutrition courses, as compared with 322 in the Kirschner data. Regarding consumer education, 962 are now enrolled versus 262. The smallest increment occurs for sewing, 919 now against 469 then -- almost a 100% expansion of participation.
>
> ... A significant point is the current involvement of fathers in PCC programs. KAI found an essentially negligible proportion of men in Center courses. CCR reports 512, compared with 1,799 mothers.

Not only are PCC's offering more services, but they are also serving more family members.

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1. Data from the two studies are directly comparable in this area, being based on totals for the Centers as reported by staff.

2. SUBJECTIVE MEASURES OF IMPACT

Perhaps the most convincing evidence of PCC impact comes from the subjective reports of the participants themselves. In Table 26 are data on the effectiveness ratings of PCC's from the parent sample.

Table 26. Ratings of effectiveness in helping the respondent families.

DEGREE OF PCC EFFECTIVENESS	TOTAL SAMPLE
Very effective	273 (71%)
Somewhat	78 (20)
Slightly	17 (4)
Not effective	9 (2)
No answer	8 (2)
Base:	385

As can be seen from Table 26, the vast majority of the respondents feel that the PCC has been very helpful to them. Twenty percent of the sample does reserve judgment, however. It is interesting to note that in comparing these findings with those of Table 37, the proportion of parents who feel that PCC has been "very effective" in helping them is smaller than the proportion who feel that PCC has been "very effective" in helping their children.

Parents were asked a series of open-ended questions with regard to how the PCC has affected various aspects of their lives.

Self-report of what PCC membership has meant:

First, parents were asked to describe in their own words all that being a PCC member has meant to them and their families. Faced with such a large, unstructured question, a number of mothers showed some obvious unease at the start. However, after thinking for a moment, almost everyone opened up remarkably and talked at length about what the project has done for them. Almost all of the responses were positive, and often strongly so. Fewer than one in twenty took a negative tone.

Table 27. Summary of verbal report from parent sample as to how PCC has affected their lives.

	TOTAL SAMPLE	LOCALE	
		Urban	Rural
Parent learned about children	198 (51%)	133 (53%)	65 (48%)
Parent is less shy, can discuss problems	190 (49)	118 (47)	72 (53)
Children are smarter	182 (47)	120 (48)	62 (46)
Children less shy, more independent	147 (38)	96 (39)	51 (37)
Parent learned home-making skills	136 (35)	79 (32)	57 (42)
More free time	77 (20)	46 (18)	31 (23)
Received medical, counseling aid	56 (15)	20 (8)	36 (26)
Received food, materials	18 (5)	7 (3)	11 (8)
Base:	385	249	136

Note: Multiple answers occurred.

Major mentions dealt with educational aspects -- that parents had learned about their children or about homemaking and that children themselves have learned much. It is interesting how frequently the process of socialization comes up. Half (49%) of the parents said that they had become more able to relate with others, to talk about themselves and their problems openly and to take part in group activities. More than a third (38%) described the same benefit on behalf of their children.

Also of note is the relatively low level of mentions of medical or counseling benefits. One may speculate that medical aid, in particular, stops being a major perceived plus once it becomes a reality. When it is a need, it is perhaps the most important aspect; but when it is obtained, it is taken more or less for granted. Mentions of medical benefits were higher in rural areas than urban because such care is harder to come by outside the cities.

Changes in feelings as mothers:

Then, they were asked to tell whether their feelings about being a parent had changed, and if so, how. Seventy-two percent of the sample described change which could be considered positive, 20% reported no changes in their feelings about being a parent, and no one reported negative change. The kinds of changes perceived and described by the mothers involve both cognitive and affective change. The following are verbatim examples of the kinds of changes described.

"PCC taught me to have patience - taught me to take responsibility towards my family in health aspects - before I let things go - never took the trouble to take them for shots - I had a horrible temper - used to hit the children a lot - now I listen to them and don't hit them. My oldest used to cringe when he saw me coming, but no more - and he's even told me about the difference."

"PCC made me a mother - before that I just gave birth - I used to run around with men a lot and I felt the kids just bogged me down - but now I really enjoy them."

"Made me feel a lot more comfortable about being a mother - I used to whip the children - but I don't do that any more."

"With children I used to lose my patience. They taught me how a child of certain ages should act so I gradually became a better mother. I was able to control my temper and respond in a better attitude. I didn't know how to handle their fighting and screaming. Then I saw how PCC teachers operated and I learned."

"I've learned that kids are individuals - before I just raised them - clothed and fed them. Now I'm aware of even little differences and praise them and give them credit for what they can do at their own speed. I feel therefore I'm a better parent, and an important person. Before I felt that anyone could do this job."

"I understand now that a mother has to do much more than just be there. I feel important as a mother."

"I used to shout and holler at the kids all the time. I feel better because I'm not being mean to them - I also have fun with them now."

"Being a mother makes me feel important - I know I'm really doing something for them."

"I used to whip first and ask questions later."

"I love the children a lot more. There are things that you don't appreciate until you learn about them. You appreciate them for what they are, little individuals. You can't love a child enough. Before I didn't really like children."

These comments are highly representative of what was said by the 277 mothers who described changes in their feelings as mothers. Essentially, according to subjective reports, there have been marked changes in the following:

1. decrease of corporal punishment
2. increase in responsible care: e.g., health nutrition, etc.
3. recognition of the needs of children
4. recognition that motherhood involves skill and knowledge
5. increase in enjoyment of children and in feelings of self-competence.

The highest percentage of mothers report positive changes in their feelings as mothers. A far greater number of women report changes in this area than they do in the other areas about which they were questioned: i.e., homemaking and feelings about self. There are a number of possibilities as to why this should be the case. PCC's have stressed child development above all else. Thus it is not surprising that more mothers have experienced change in this area than in any other. In fact, these data suggest that the respondents in our sample have genuinely internalized PCC values. It is also possible that it is less threatening to admit to changes in mothering than in the self: a number of mothers who reported changes in their feelings about being mothers said that there was no way in which the PCC had changed their feelings about themselves and that they've always been "fine." As was already pointed out, some mothers see the program as one which is advantageous to children, but they deny any need of the program for themselves. This is analogous to the well-known clinical phenomenon of the mother who insists she has come for treatment only for her child, not for herself.

Changes in feelings as a homemaker:

Forty-one percent of our sample report positive changes in their feelings about being homemakers and 58% either report no change or say they can't think of any changes in this area. The following comments are quite characteristic of what has been said by those who report change.

"Used to spend my whole check in a few days and then we'd have nothing left to eat. I learned to budget and plan."

"Before I didn't understand ways to helping myself - I couldn't sew - couldn't cook - wasn't budgeting my money and now I do all of this."

"I learned what we should be eating to stay strong and how to fix it - didn't know how to read a thermometer or do anything in health."

"I used to dislike everything about taking care of my house - now it's kind of fun - I know I make it look nice and I like to have people over to see it."

"My house used to be a pigpen and never had nothing nice about it. I learned to make things for it and it really looks good."

Many programs do not stress homemaking skills to the extent that they stress child development. However, it is clear that many mothers feel that they have been helped in the following areas:

1. budgeting
2. shopping - food preparation - nutrition
3. home decorating

Changes in feelings about self as a person:

Forty-two percent of all respondents described changes in their feelings as people; 58% report no change, or say that they cannot answer the question. The following examples are typical of the kinds of responses given by women who report change.

"When I first joined PCC I was so shy I couldn't even talk on the phone - this program brought me out of a shell and taught me how to associate with people - I've gotten self-confidence - for the first time I know what's going on in the community and I can take part in it."

"I'm more easy with people. I used to be depressed all the time and just stay in the house."

"If I have a problem I can count on them to listen and to help - and they have helped with many problems. Before I was all alone."

"I feel more adequate as a person, my life has meaning to it. My relationship to my husband has improved because I have been able to stand up to him in showing him how important a woman's role is."

"I was withdrawn, felt shy and couldn't meet people. I started to feel needed and wanted because I was doing volunteer work at the Center. I don't feel so isolated and different anymore."

"I am less nervous. I feel wanted more because people here care about each other."

"I used to be alone to the point of thinking about suicide. But here I feel like I have a family and friends."

"More patience. More curiosity. More life."

"I'm the best example. Three years ago I didn't talk to anybody. Now I'm on the school board, and the welfare board, and I speak to anybody."

Essentially the following changes are mentioned by the 161 women who feel that they have changed as human beings.

1. a decrease in shyness, an ability to relate to people and to make friends
2. a decrease in feelings of isolation, in feelings of being totally without support or nurturance from any source
3. increase in feelings of self-competence and of self-esteem
4. increase in feelings of pleasure as wives, mothers, and human beings
5. diminution in feelings of anxiety and depression.

Mentions of problems:

As stated earlier, not every mother was happy with her family's experience of PCC membership. A few were decidedly negative, and comments representative of the major problems follow.

"They hire people who don't live here. There are a lot of people here - good ones - who need the work. You can see that. Yet they went all the way to (city in next county) to hire someone. And my husband wanted to join the Board but they wouldn't pay for his time off from work. It takes three days and he can't afford that. They paid for another family, but we couldn't join."

"They say they're going to come to your house and work with your child at such and such a time, but they don't come. I know one family that quit because nobody ever came. If they say they're going to come, they should come - what's the point?"

"They said you could come here and get training for a job. We didn't get job training."

"I think that instead of just coming, they should help train you and get you a job. Because when your children go to school you can't come to the Center anymore."

"I would like to take more than one course. It should have more activities and stipends or get us a job to use our skills."

"I got what I didn't expect - a headache and a lot of misunderstanding and confusion. They should take care of business and stop all this confusion."

(Q. Has being a PCC member helped you?) "For me or the child, no. The accent is on feeding them well. It's not balanced in class. They could do more things. We need a better system of transportation. They eat, sing, and go home."

"I didn't expect all this stuff of changing Directors every two months. They should have parties for kids and parents."

"My child comes here once a week - about one hour here. They should spend more time and money on the children, less on adults. Kids get shy with mother in the room."

"The Center should have more days for children to come to classes and more hours. Teachers don't teach them anything."

"I thought I should get free medicine for my child and me."

CHAPTER II

THE CHILDREN OF THE PCC

In approximate descending order of frequency, negative comments dealt with:

1. Absence of job training or of other assistance toward a career (counseling, placement, etc.) These mentions accounted for the greater part of all unfavorable response.
2. Not enough educational programs (usually for children).
3. General confusion -- high turnover, poorly planned programs, lack of organization or direction.
4. Absence of specific benefits other than education (i.e., medical care, arts and crafts).

INTRODUCTION

In this chapter will be presented the data descriptive of PCC children: who they are, what they do at the PCC, and what their mothers feel the children have derived from PCC membership. Once again, it must be recalled that the impact study has yet to be done and that these data are preliminary and do not represent an in-depth study of focal children.

A. WHO ARE THE PCC CHILDREN?

Demographic and structural characteristics of the childrens' families have already been described.

In the CCR sample of 385 families, there are 565 PCC-enrolled children, among whom the median age is 26 months. In terms of the national sample, the number of focal children being served by PCC age groupings are presented in Table 28 below.

Table 28. Total number and groupings of all children served by the PCC.

	NO. OF CHILDREN	NUMBER OF CENTERS
Infants	609	24
Toddlers	676	21
Runabouts	791	24
Infants/toddlers	483	5
Toddlers/runabouts	394	3
Infants/toddlers/runabouts	221	4
Total	3,174	

The PCC's are serving a total of 3,174 children. The finding that, overall, relatively more older than younger children are being served corroborates the mean age of 26 months for children in the CCR sample. In the majority of the Centers, a distinction is made between infants, toddlers, and runabouts. However, in 12 of the Centers, these distinctions are made only partially or not at all.

The three groupings of children are usually separated (when they <u>are</u> separated) quite pragmatically on the basis of their physical mobility -- as the terms used imply. Centers do not bracket youngsters by age alone because of wide individual differences in development. Generally speaking, though, infants are under the age of one, toddlers from approximately one to two or two and one half, and runabouts from there upward.

Most PCC's segregate the three groups for program purposes. However, in most Centers children from all groups do intermingle at times. On the other side of the coin, Centers that serve all children together usually have an alcove for infant cribs and, perhaps, areas with equipment more for toddlers than for runabouts or vice versa. Very few PCC's maintain either complete separation or <u>complete</u> intermingling of children.

B. WHAT DO CHILDREN DO AT THE PCC?

In this section we discuss what children, both focal and older siblings, do at the PCC: the kinds of programs in which they participate and the kinds of services with which they are provided. Some of these data were obtained from the parent sample, other data were obtained from the Director or from staff designated by the Director to provide program information.

1. Focal children

Children in the various age groups are served either in their homes, at the PCC's, or in group homes. In Table 29 below are presented the number of children in each PCC grouping, for each program location.

Table 29. Number of children within each age grouping being served within a locale.

	NO. IN HOME	NO. IN PCC	NO. IN GROUP HOMES
Infants	273	395	24
Toddlers	105	683	0
Runabouts	146	673	45
Infants/Toddlers	464	275	0
Toddlers/Runabouts	104	109	0
Infants/Toddlers/ Runabouts	184	184	24
Totals	1,276	2,319	93

From inspection of Table 29 it can be seen that the greatest number of children are served at the PCC's themselves. In most Centers children are served both in the Center and in the home. In the minority of Centers there is no outreach component and children are served exclusively at the Center. In some cases, all or some of the outreach children served in the home participate in the in-Center program. In other PCC's distinct groups are served in the home or in the Center exclusively. In some Centers the same group of children is served both in the Center and in the home. The largest group of children served in the home are in the rural PCC's where the program serves a number of counties whose participants cannot reach the Center site.

Centers differ a great deal in the number of hours per week that the Center-based program is offered to any given child. The following are the most common within PCC time allotments.

In six Centers 464 children are in the Centers 25-40 hours per week. These Centers serve toddlers, infants, and runabouts five days per week; one session each day. Three of these Centers also serve children in the home.

In fourteen Centers 1,025 children are served in the Center from 8-20 hours per week. These children come either four or five times a week, depending on whether or not the Center reserves one certain day for staff training, meetings and preparation of materials. These children come either for a morning or afternoon session, and a session can be anywhere from two to four hours.

In ten Centers 798 children are served from one to eight hours a week. These children come either one or two times a week for either a morning or an afternoon session and stay from one to four hours at a time. Some of these children may also be served in the home on the days they do not come to the Center.

Within any given Center, the number of hours of within-PCC service may differ according to the age of the child or the program status of the mother. For instance, in some programs infants come twice a week for two hours a session, and toddlers come four times a week for two hours a session. In another program the children of mothers attending school come to the PCC every day, whereas the children of mothers in an outreach program come one day a week.

Table 29 shows that 1,276 children are served in an in-home program. Those Centers which send staff to the homes, generally serve children from one to three hours a week. In home-based programs the staff works with the mother and child and the mother is instructed in what activities will stimulate the child. In some cases the mothers are given assignments to practice and follow-up is made at the next home visit.

Three Centers report home group day care serving a total of 93 children. The children cared for in group homes are generally there for five full days a week, five to seven hours a day.

The Centers were asked to choose those child development models which best characterized their programs. The patterning of choices is shown in Table 30 below.

Table 30. Number of PCC's reporting various overall program types.

MONTESSORI METHOD	GROUP DAY CARE	STRUCTURED OR PACKAGED LEARNING	SUPPORTIVE SETTING	GENERAL CHILD DEV.
8 (24%)	11 (33%)	15 (46%)	22 (67%)	26 (79%)

The majority of Centers reported more than one of the types as being descriptive of the their program. The general child development approach characterized 79% of the Centers. The second largest response was a supportive setting model reported by 67% of the Centers. In most cases of multiple response the combination of these two approaches was selected. Of the total number of Centers, 46% report using a structured or packaged learning program. Some of these are combined with the Montessori method by 24% of the Centers. Eleven PCC's report a group day care model, but this does not imply that all 11 are serving the same children five full days a week.

Of the eight PCC's reporting a Montessori approach (at least in part), six had appropriate Montessori equipment in the view of CCR's interviewers. However, little evidence of teaching techniques specific to Montessori was found even at the Centers with such equipment.

Five of the eight PCC's mentioning Montessori also reported having structured or packaged learning programs. That accounts for a third of the Centers reporting structured approaches. It appeared to the interviewers that few of the other ten followed more than pieces or outlines of any well documented learning approach (e.g., Ira Gordon's model). Rather, Directors listing a structured program seem to be referring to program elements or philosophy that go beyond general child development or a simple supportive setting.

Directors were asked to rank the degree of importance of physical, social/emotional, and cognitive development for infants, toddlers and runabouts. These data can be seen in Table 31.

Table 31. Importance rankings of children's developmental components by Directors.

	INFANTS		
	PHYSICAL	SOCIAL/ EMOTIONAL	COGNITIVE
Most important	25 (76%)	8 (24%)	- -
Second	7 (21)	16 (49)	10 (30)
Third	1 (3)	9 (27)	23 (70)
Base:	33	33	33

Table 31. (continued) Importance rankings of children's developmental components by Directors.

TODDLERS

	PHYSICAL	SOCIAL/ EMOTIONAL	COGNITIVE
Most important	8 (24%)	18 (55%)	7 (21%)
Second	18 (55)	8 (24)	7 (21)
Third	7 (21)	7 (21)	19 (58)
Base:	33	33	33

RUNABOUTS

	PHYSICAL	SOCIAL/ EMOTIONAL	COGNITIVE
Most important	4 (12%)	22 (67%)	7 (21%)
Second	6 (18)	11 (33)	16 (49)
Third	23 (70)	- -	10 (30)
Base:	33	33	33

It can be seen from the table that physical development was ranked most important for infants, and social/emotional development ranked second. That is, 76% of the Directors ranked physical development most important for infants and 49% ranked social/emotional development as second in importance for infants. At all the PCC's physical development is promoted through grasping, reaching, pushing, and pulling activities. Carpeted areas are reserved for crawling, sitting, and stretching movements. Staff works with children to encourage standing and walking. Appropriate equipment is used to aid in physical development.

Social/emotional development is ranked most important for toddlers by more than half (55%) of the Directors. Physical development is ranked second in importance for the toddlers by more than half the Directors as well. The supportive setting model reported by more than half the PCC's provides the basis for social/emotional development. Children are given warmth and support, are taught to share and be part of a group. Physical development is fostered through the use of indoor and outdoor equipment. Balls, jump ropes, climbing apparatus, etc. provide for large muscle development and coordination. Manipulative equipment aids in small muscle development for children of this age.

A decided majority (67%) of Directors rank social/emotional development most important for the runabouts. Cognitive development ranks second for this age group. The supportive setting continues while the child begins to learn some basic skills. Colors, shapes, numbers, are taught. Working with small groups

of children the staff introduces basic reading and number readiness concepts and the child begins to be able to sort, identify and discriminate.

Thus, as the child grows from infancy to the runabout stage, the clear pattern of Directors' feelings is that physical aspects decline in importance while social/emotional ones become paramount and cognitive ones increase.

2. Older siblings

Twenty-four PCC's maintain special programs for older siblings. Sixteen Centers provide recreational activities, e.g., after-school program, summer camp; six Centers provide tutoring, and two serve a meal or a snack.

Medical services are secured to older siblings by 27 Centers; dental care is secured in 20.

C. WHAT HAS HAPPENED AS A RESULT OF PCC MEMBERSHIP?

As with the parents, the preliminary impact data can be described as being of two kinds: 1) objective data on the numbers of children who have received specific kinds of services which are assumed to be of benefit. These data are presented separately according to whether the service is reported by their parents or by PCC staff; 2) subjective reports of parents on how they feel their children have benefited from PCC participation.

1. OBJECTIVE MEASURES OF IMPACT

In Table 32 below, are presented the data from our parent sample on whether or not the Center has done something specifically for their children's health.

Table 32. Number of adult respondents who report receiving medical care for their children.

	TOTAL SAMPLE	LOCALE	
		Urban	Rural
Receive medical care	262 (73%)	142 (57%)	120 (88%)
Do not receive	123 (27)	107 (43)	16 (12)
Base:	385	249	136

Nearly three out of four mothers report that their children have received medical services. It is to be noted that in rural areas the children in almost nine out of ten families receive medical services through their PCC membership.

Among the 262 mothers reporting that their children get medical care, 83% report checkups and 65% mention shots and immunizations. Only 20% mention ongoing treatment.

In Tables 33 and 34 below, are presented the health data on the national PCC child population. These are the data which were supplied by Center or affiliated health agency staffs at the 27 PCC's which offer medical care to children.

Table 33. Checkups/tests/immunizations secured for PCC children and the number of Centers reporting each service.

SERVICE	NO. PCC's SECURING FOR CHILDREN	NUMBER OF CHILDREN SERVED
CHECKUPS/TESTS		
Physical	20	1990
X-ray	11	229
Visits	17	767
Hearing	17	924
Tuberculosis	18	1487
Simple anemia	20	1423
Sickle cell anemia	11	545
Lead poisoning	8	357
IMMUNIZATIONS		
Polio	27	2038
Smallpox	26	1257
DPT	27	2181
Measles	26	1211
German measles	21	1008
Mumps	7	178

Table 34. Medical treatments secured for PCC children and the number of Centers reporting each kind of treatment.

SERVICE	NO. PCC's SECURING FOR CHILDREN	NUMBER OF CHILDREN SERVED
Emergency (anything)	12	1,505
Sickle cell anemia	6	58
Simple anemia	17	398
Lead poisoning	6	22
Malnutrition	13	168
Heart disease	6	9
Respiratory disease	14	435
Back problems	-	-
Tuberculosis	5	8
Corrective operations	18	94
Skin diseases	16	126
Vitamins	18	799

The parent sample was asked to report whether or not their children had received any dental care as a result of PCC. These data are presented in Table 35 below.

Table 35. Number of respondents who report receiving dental services for their children.

	TOTAL SAMPLE	LOCALE	
		Urban	Rural
Receive dental care	105 (31%)	49 (20%)	56 (41%)
Do not receive	280 (69)	200 (80)	80 (59)
Base:	385	249	136

As can be seen from Table 35, children in almost one out of three families have had dental care and in the rural areas this proportion is substantially higher. Of the 105 mothers who report dental care for their children, 77 report dental checkups and 55 report cleanings and fillings.

The data provided by Center staff on dental interventions provided to PCC children at 20 PCC's are presented in Table 36 below.

Table 36. Dental care secured for PCC children and the number of Centers reporting each kind of service.

SERVICE	NO. PCC's SECURING FOR CHILDREN	NUMBER OF CHILDREN SERVED
Checkup	19	856
Fillings	16	402
Extractions	14	168
Cleanings	15	436
Fluoride	11	257
Peridontal work	5	94
False teeth	1	2

The parents in the CCR sample were asked whether their children are given a meal or snack at the PCC. Ninety-one percent of the parents answered affirmatively. In fact, meals are provided by 30 PCC's. Three of these Centers provide two full meals a day, 20 provide a meal and a snack, four provide one meal, and the remaining three have snacks only. In addition, nine PCC's report that a total of 15 children are maintained on special physician-prescribed diets.

Thus, in terms of objective measures it can be said that through PCC a large proportion of children get medical care, a substantial number of children get dental service, and a vast majority of children are given some nutriment.

2. SUBJECTIVE MEASURES OF IMPACT

Parents were asked to rate the effectiveness of the PCC in terms of services for children. These data are presented in Table 37 below.

Table 37. Ratings of PCC effectiveness in helping the children of respondents.

	TOTAL SAMPLE
Very	316 (82%)
Somewhat	51 (13)
Slightly	14 (4)
Not very	5 (1)
Base:	385

As can be seen from Table 37, the overwhelming majority (82%) of parents interviewed feel that their PCC has been very effective in helping their children. That figure may be compared directly with the 71% who ruled their PCC's as very

effective in helping the family as a whole (Table 26 on page 55) This could be a function of the fact that a number of interviewees clearly deny any need of the program for themselves and say that they have joined only for the child's sake. There are also a number of mothers who expected to get jobs and material services who feel they have not gotten as much as they would like. These are the mothers who feel that the needs of children are more easily met than the needs of adults. They feel that while the needs of children have been met, their own have not been fully met.

Parents were asked an open-ended question about what they felt their children had derived from PCC participation. Their answers were coded into the following categories: cognitive skills, e.g., learning new songs, games, numbers, etc., social skills, e.g., decrease in shyness, less clinging to mother and increased interaction with others; self-help activities, e.g., shoe tying, physical development and general care.

The results of these tabulations are presented in Table 38 below.

Table 38.What PCC has taught children.

	TOTAL SAMPLE
Cognitive skills	240 (66%)
Social skills	243 (67)
Self-sufficiency (tying own shoes, etc.)	136 (37)
Physical development	43 (43)
General care	17 (5)
Total parents reporting	363

As can be seen from Table 38, the majority of parents were impressed with the increase in learning and in social skills exhibited by their children. Many were also impressed with the growth in independence of the children and their ability to do things themselves. Many parents made the comparison between their older children and their PCC children, or between their PCC children and others in the neighborhood, and felt strongly that the PCC children were "way ahead" of the others. In fact, when asked whether in their opinion PCC had taught their children anything useful, 92% of the parents said, "yes." The following are some representative verbatim excerpts of the kinds of answers

given by mothers when they were asked to tell what their children had derived from PCC.

"He can grasp and he's been exposed to puzzles which I hadn't thought of giving him. Being here with other children he's more outgoing - not onto me as much."

"He learned to talk faster - he asks for what he wants."

"They've trained her how to eat by herself and play with other children."

"My little girl has learned to talk with sentences. She is much more independent. She can do more on her own."

"He's not afraid of people - learned to eat by himself."

"They learned how to put their clothes on correctly."

"He talks better. He learned to get along with others. He's less bashful. He don't cling to me now - more independent."

"Know shapes, colors, recite nursery rhymes - Then I teach them at home so they won't forget. It gives them incentive to learn."

"He eats better, likes to investigate things and play with the kids. He learned to share."

"Taught her to play with toys, with other children, how to sing, hang up her coat and dress herself. I see a lot of differences. If I were staying at home with her she'd be on the cranky side."

"He can handle things. He knows who he is and he can get around by himself - dresses himself - even knows where he lives. And he has learned to share things which he didn't used to do."

"Sizes, shapes, learning to identify pictures. He's learned to talk more clearly - has picked up vocabulary. Button-snap and zip, but not tie. Name, address, and phone. Just complete different atmosphere."

"She got potty trained here and learned to brush her teeth. Now she asks for snacks and vitamins at home. She sets table now. She knows colors. She can dress and undress. She knows where everything goes and the parts of the body."

Summary of children's data

Overall the PCC's report a total of 3,174 children being served -- an average of almost 100 per Center.

1. There is a slight preponderance of runabouts (2.5 years or older) over toddlers (1-2.5 yrs.), and of toddlers over infants (0-1 year). This finding can be accounted for in terms of the age ranges adopted, i.e., the age intervals are broader with increased age.

2. Enrolled children have a mean age of 26 months -- a bit beyond the midpoint of the age range for PCC enrollment.

Two thirds of the Centers separate the three children's groupings for program purposes, although complete physical separation is rare. As for location of children's sessions:

3. Twice as many children are served at the PCC's as in the home.

4. More than 500 are served in both places.

With regard to developmental models:

5. Most Centers reported either a general child development scheme (79%) or a generally supportive setting (67%) or both.

6. Fifteen mentioned structured learning programs and eight the Montessori Method, there being considerable duplication between those groups. By "structured" most PCC's apparently refer to elements rather than to an entire planned program.

3. An overall profile of Directors' views about the importance of developmental aspects reveals a decided shift in thinking as the child grows older. Physical development is considered most important for infants, social/emotional for toddlers and even more so for runabouts, with cognitive development increasing in importance with runabouts.

Reports of medical and dental services to children from 30 of 33 PCC's yield the following illustrative figures:

1. Almost 2,000 children have received general physical examinations, and more than 2,000 have received almost 8,000 immunizations (DPT and polio being the most frequent).
2. More than 3,500 cases of preventive or interventive treatment are reported. Approximately two fifths of these are emergency instances, with approximately 400 treatments each being given for respiratory diseases and for simple anemia.
3. The Centers report 856 dental checkups and more than 400 mentions each of fillings and cleanings.

Thirty PCC's serve food:

4. Twenty-seven of them serve at least one full meal per day. The other three serve snacks only.

Finally, 95% of the mothers in CCR's sample say they feel their children have learned things since joining the Center:

1. Mentions of social skills were on a par with cognitive aspects -- two thirds of all parents who reported something learned.
2. Physical development and self-sufficiency (in dressing and personal hygiene) were each mentioned by approximately two fifths of those mothers.

INTRODUCTION

In this chapter will be presented the data descriptive of PCC staffs: who they are, what they do at the PCC's and what the community people working at the PCC's have derived from the experience. The data come from one section of the Director's Questionnaire, which was completed by 32 of the 33 Centers visited, and from 327 staff members who were interviewed individually at the 33 Centers.

In terms of the relative numbers of professionals and non-professionals involved, operational leadership of an area of responsibility was adopted by CCR as a de facto definition of "professionalism" without regard to education. This seems to be the impliçit definition used at a majority of PCC's and CCR adopted it because the definition of professional status varies from Center to Center without any consistency. Using that definition, 160 professionals were drawn into CCR's staff sample. An approximately equal number (167) of non-professionals were interviewed as well, 70 of whom were or had been PCC member parents.

A. WHO ARE THE PCC STAFF?

Sex

Data on the sex distribution of staff members are derived exclusively from the 327 staff interviews conducted by CCR.

Table 39. Sex of staff in CCR sample.

SEX	TOTAL	PROFESSIONALS	NON-PROFESSIONALS
Male	37 (11%)	25 (16%)	12 (7%)
Female	290 (89)	135 (84)	155 (93)
Base	327	160	167

PCC staffs, like the adults whom they serve, are primarily female in character. Almost nine out of ten staff members are women. Male staff members, where they exist at all, tend to be either Directors/Administrators or Drivers/Maintenance personnel. The proportion of men in professional capacities is double that in non-professional jobs, but even for the former it reaches only 16% of the total number of professional jobs.

Age

Data on the age of PCC staff members are presented in Table 40.

Table 40. Age of staff in CCR sample.

AGE	TOTAL	PROFESSIONALS	NON-PROFESSIONALS
30 or under	150 (46%)	76 (48%)	74 (44%)
31 to 40	85 (26)	45 (28)	40 (24)
41 to 50	61 (19)	28 (18)	33 (20)
51 and over	30 (9)	10 (6)	20 (12)
No answer	1 (*)	1 (1)	- -
Base	327	160	167

Almost half of the staff interviewed are 30 years of age or younger. More than an additional fourth are between 31 and 40. The age distribution of non-professionals is very similar to that of professionals. Also, staff members are for the most part peers in age of parent participants. However, 28% of the staff sample is over 40, whereas only 5% of the parent sample is over 40.

Education

Data on the educational background of PCC total professional staff, and of the CCR professional staff sample, respectively, are presented in Tables 41a & b below. In Table 41a the number in parentheses under each staff position indicates the number of people at all PCC's in that position. For purposes of data

reduction, where there is more than one professional within a particular job category at any given Center, the average number of years of education for the job category is presented here.

Table 41a. Education of total PCC professional staff; average educational level for each job category.

EDUCATIONAL LEVEL	DIRECTOR (32)	SITE SUPERVISOR (10)	PARENT EDUCATOR (13)	CHILD EDUCATOR (63)	SOCIAL SERVICE (26)	NURSE (17)	ADMINIS-TRATOR (13)	HEALTH EDUCATOR (8)	CLERICAL (7)
9 years or fewer	-	2	1	1	1	-	-	-	-
High school or equivalent	4	-	2	3	1	2	3	1	4
Some college/ business school	3	-	1	5	-	-	-	-	2
College degree	11	2	5	13	11	14	5	1	-
Graduate work or degree	14	1	1	6	5	-	4	-	-
No answer	-	1	-	-	-	-	1	2	-
No. of Centers with that position	32	6	10	28	18	16	13	4	6

Total professional staff members = 192

At 25 Centers the Directors have at least a college degree; 14 have gone on to graduate work. At six Centers the average education of the Parent Educators is at least a college degree, at four Centers it is less. At 19 Centers the

average education of the Child Educators is at least a college degree and at five it is some college. At four Centers the average education of the Child Educators is a high school degree or less. The average education among Social Service Supervisors and Nurses at the vast majority of Centers where they are employed is a college degree. The incidence of college education or beyond, among professional staff, as reported by Directors, is 43%.

Table 41b. Education of professional staff in CCR sample.

EDUCATIONAL LEVEL	PROFESSIONALS
9 years or fewer	14 (9%)
High school or equivalent	17 (11)
Some college/ business school	42 (26)
College degree	52 (33)
Graduate work or degree	33 (21)
No answer	2 (1)
Base	160

Among the 160 professionals interviewed by CCR staff at 33 PCC's, 54% have obtained a college degree, some going on to graduate work. The somewhat greater proportion of better

educated professionals found in the CCR sample (as contrasted with the total PCC population) is probably a function of the CCR effort to interview the leadership position for any component within a PCC. Thus, for instance, there are 66 professional Child Educators at 28 Centers. CCR staff did not interview every Child Educator; rather, those in supervisory positions were selected. It is probable that those in supervisory positions have attained a higher level of education than the professionals whom they supervise. Also, as has been explained, information obtained from the Director was averaged in those cases of multiple staff within a job category. The data from CCR interviewing were not averaged, but represent individuals. Thus, in averaging there could have been a bias toward a slightly lower level of education.

Data on the educational employment requirements for the 488 PCC total non-professional staff sample are presented in Tables 42a & b below. In Table 42a the number in parentheses under each staff position indicates the number of people, at all PCC's within that position. All other numbers in the table refer to the number of Centers which do or do not maintain educational requirements.

Directors could not be expected to specify the exact number of years of education for each and every PCC non-professional staff member. Thus, they were asked only whether or not their PCC had any educational requirements.

Table 42a. Education requirements for total PCC non-professional staff.

	TEACHER AIDES (187)	SOCIAL SERVICE AIDES (88)	FOOD/ HEALTH AIDES (47)	DRIVER/ MAINTE-NANCE (52)	CLER-ICAL (58)	OTHER (41)
High school or equivalent	11	8	-	1	13	2
No requirement	21	8	19	29	17	4
Number of centers reporting that position	32	16	19	30	30	6

At the majority of Centers, there are no educational requirements for non-professional staff. Teacher Aides, Social Service Aides, and Clericals are expected to have a high school or equivalent degree at nearly half the Centers. Of course whether or not such a degree is expected provides only a lower bound estimate of the number of people who have it. A more representative estimate of the educational level of non-professional staff is available from CCR interviews with 167 non-professionals.

Table 42b. Education of non-professional staff in CCR sample.

EDUCATIONAL LEVEL	NON-PROFESSIONAL
9 years or fewer	58 (35%)
High school or G.E.D.	63 (37)
Some college/ business school	44 (26)
College degree	2 (1)
Graduate work or degree	- -
Base	167

Sixty-four percent of the non-professional staff interviewed has at least passed their equivalence or has gone further and has had some college or business school.

It is interesting to compare the educational background of those non-professional staff members who are also PCC parents, with non-professional staff who are not parents, and with the educational data on PCC parents already reported in the chapter on parents. These data are presented in Table 43 below.

Table 43. Educational background of non-staff parents, staff parents, and other non-professional staff in the CCR sample.

EDUCATIONAL LEVEL	NON-STAFF PARENTS	PARENTS ON STAFF	OTHER NON-PRO STAFF
9 years or fewer	95 (28%)	44 (38%)	22 (24%)
10 to 11 years	124 (37)	16 (14)	6 (6)
High school/ G.E.D.	86 (25)	32 (28)	35 (36)
Some or all college	30 (9)	24 (20)	34 (35)
Other	2 (1)	- -	- -
No answer	2 (1)	- -	- -
Base	339[1.]	116[2.]	97[3.]

1. This total represents the 385 parents in the parent sample minus the 46 parents on staff.
2. This total represents the 70 parents on staff interviewed as staff, and the 46 parents on staff interviewed as parents.
3. This total represents the actual number of non-parent, non-professionals on staff.

Almost two thirds of the non-staff parents have not completed high school (or its equivalent). The corresponding proportion is approximately half among staff parents, and it drops to less than one third among other non-professional staff members. Clearly the non-parents among the non-professional staff have had more education than either the parents on staff or the parents who are not on staff. Nearly three quarters of these non-parents have finished high school or have had at least some college. Of the parents on staff, 48% have finished high school or have had at least some college. Among the non-staff parents only 34% have finished high school or have had some college.

In the absence of widespread educational criteria for hiring parents, either most Directors or Advisory Councils prefer family members with more schooling for staff positions, or those parents who have had more education are more motivated to seek PCC employment.

Ethnic Background

The data on the ethnic background of the CCR sample are presented in Table 44 below.

Table 44. Ethnic background of PCC staff in CCR sample.

ETHNIC GROUPING	TOTAL	PROFES-SIONALS	NON-PROFESSIONALS
Black	134 (41%)	56 (35%)	78 (47%)
Mexican-American	29 (9)	10 (6)	19 (11)
Puerto Rican/ Other Spanish descent	9 (3)	5 (3)	4 (2)
Other Caucasian	134 (41)	83 (52)	51 (31)
Indian	13 (4)	1 (1)	12 (7)
Oriental	7 (2)	5 (3)	2 (1)
Other	1 (*)	- -	1 (1)
Base	327	160	167

With respect to ethnic background, staff sample proportions yield a picture somewhat different from that of the parent sample. The largest deviation involves Blacks and "Other Caucasians." The latter comprise two fifths of the staff sample, while accounting for but a quarter of the parent sample. Blacks represent 41% of staff, but 54% of the parents interviewed. Points of disparity exist for other ethnic groupings, too, but they are quite possibly a function of sampling fluctuations. Thus, for example, if a PCC in an Indian area has many parents enrolled but a staff complement in

the normal range, CCR's very sampling objectives would create an imbalance.

Another point to consider is that over-sampling occured with respect to professionals, to include the breadth of program components. Since the ethnic distribution of non-professionals (Black: 47%; Other Caucasian: 31%) is similar to the ethnic distribution of the total PCC parent population (Black: 55%; Other Caucasian: 26%), there would be greater similarity between ethnic background of staff and parents if the CCR staff sample did not include a relatively large proportion of professionals. Nevertheless, there are fewer Black and more Caucasian staff members than is the case among parents.

Place of residence

Data on the number of staff who live in or out of the PCC catchment area are presented in Table 45.

Table 45. Catchment area residence of staff in CCR sample.

RESIDENCE	TOTAL	PROFESSIONALS	NON-PROS
Inside catchment area	204 (62%)	69 (43%)	135 (81%)
Outside catchment area	123 (38)	91 (57)	32 (19)
Base	327	160	167

Slightly more than two fifths of the professionals, as contrasted with four fifths of the non-professionals, live in the immediate area of their PCC's

Summary

In summary the following points can be made about PCC staff:

1) PCC staff in 89% of the CCR sample are females. The higher proportion (16%) of males occurs among professionals.

2) In the CCR sample professionals and non-professionals alike tend to be 30 or under (46%). An Additional 26% are between 31 and 40.

3) In the CCR sample of professionals, 54% have a college degree or have done some graduate work. In the total PCC professional population 43% have had this amount of education.

4) In the CCR sample of non-professionals, 63% have finished high school or have some additional college or business school experience.

5) Non-professional staff who are not PCC parents have on the average attained a higher level of education than have PCC parents on staff. PCC parents on staff tend to be better educated than are their non-staff counterparts.

6) The ethnic background of PCC professional staff does not exactly match the ethnic background of PCC parents. Professional staffs are weighted more heavily in the direction of Caucasians than the parents, who are predominantly Black. Non-professional staffs are represented in approximately the same ethnic ratios as the parents they serve.

7) Forty-three percent of the professionals and 81% of the non-professionals live within the catchment area.

Comparison between KAI and CCR staff data.

Data from the CCR staff sample show a marked similarity on all of the variables covered thus far: i.e., sex, age, education, ethnic background, and residence within the catchment area. In a number of instances the data are almost identical. For instance, KAI reports 86% women on the total PCC staff; CCR reports 89%. KAI reports 60% of all PCC employees as catchment area residents; CCR reports 62%.

B. WHAT DOES STAFF DO AT THE PCC?

Job Descriptions

The variety of professional staff positions have already been presented in the context of the discussion in the previous section of this report on staff educational background. For the purposes of clarity, since these positions will now be discussed according to job function, they are presented once again in Table 46.

Table 46. Number of total professional and non-professional staff members reported by 32 PCC Directors.

PROFESSIONAL STAFF	NUMBER OF STAFF MEMBERS	NUMBER OF PCCS REPORTING THE POSITION
Directors	32	32
Site Supervisors	10	6
Administrators	13	13
Parent Educators	13	10
Child Educators	66	28
Social Service Supervisors	26	18
Nurses	17	16
Health Educators	8	4
Clerical	7	6
Total	192	32
NON-PROFESSIONAL STAFF		
Teacher Aides	202	32
Social Service Aides	88	16
Health/Food Aides	47	19
Drivers/Maintenance	52	30
Clerical	58	30
Other	41	6
Total	488	32

Among professional staff, a Director is the only position which is common to all PCC's. Directors describe their jobs as one which requires them to act as administrators, as staff supervisors, and as community organizers. Directors vary a great deal in the degree to which they stress one aspect or another of their jobs.

All rural PCC's have more than one site. Since Alaska was not covered and the two sites of Lafayette, Georgia (Dalton and Summerville) were treated as independent Centers in data analysis, there are nine other rural Centers in the study, comprising a total of 27 "operating" sites (where child and/or parent activities are provided). One urban PCC has a second site as well, all others being single-location Centers.

Of the total of ten multiple-site Centers surveyed, four have an overall Director who heads day-to-day operations at one of the sites. Other Directors head central staffs at "non-operating" sites located anywhere between 15 and 100 miles from the operating ones.

To complete the leadership picture, six Centers have established the position of Site Supervisor -- there being ten of these in total. Site Supervisors act as "Directors-on-location," although every one reports to his or her overall Director. Sites with no specially designated supervisor are administrated through telephone communications and visits by the overall Director.

Thirteen Centers have an Administrator or an Assistant

Director position. The Assistant Director either takes over most of the administrative effort and allows the Director to act as a staff supervisor, or he acts as the overall supervisor and allows the Director to devote his time to administrative issues. Most of these Assistant Directors are in urban Centers.

Parent Educators are reported by ten, and Child Educators by 28 of the Centers. Operationally, it is extremely difficult to separate these two classes of staff. Except for those ten Centers where there is a Parent Educator whose work is clearly with parents, the work of the Child Educator in many Centers is with parents as well as with children. In other words, in many Centers the Child Educator, variously called Infant or Toddler Coordinator or Childhood Specialist, has the responsibility of discussing the progress and behavior of each child with the parent. It is these discussions which form the core of the parent program in early childhood in these Centers. Thus, it should be clear that the Child Educators in many Centers where there is no Parent Educator do a great deal of parent education. For the purposes of data analysis, those who work with children primarily are classed as Child Educators. Those who are classed as Parent Educators have the primary responsibility for the parent education program. Not all of these Parent Educators teach child development; some of them teach family life education or home management. Three Centers have two different parent education positions; one Parent Educator teaches parents about early childhood, the other teaches family life education.

Eighteen Centers report a Social Service Supervisor. Several Centers have more than one Social Worker on staff. These are the Centers in which each family is assigned to a Social Worker, or a Social Work Aide, who is responsible for seeing at least the mother on a weekly basis. Social Workers vary markedly in terms both of education and of overall orientation. At 11 of the 18 Centers, the social workers have a college degree (but not MSW), at two of the Centers they have less than a college degree and at five Centers they have had some graduate work or have an actual degree in social work. Some of these Social Workers emphasize referral to, and coordination with, other agencies and arrangements for the delivery of material services; others emphasize counseling and a psychotherapeutic relationship with clients.

Sixteen PCC's have Nurses on staff. Those with none rely on other staff members to serve a liaison function between PCC, client, and medical facility. In those Centers which do have a Nurse on staff, she maintains medical records on each family, reminds mothers when appointments are due, follows up to see whether the appointment was kept, and serves in the role of Health Educator. Some PCC Nurses also give some direct service to children, e.g. shots, eye tests, follow up on prescriptions.

At four Centers there are Health Educators. These are found generally in the Centers which have no Nurse on staff; they take over the coordination and education functions. The Health Educator may also teach such topics as nutrition, although this may be the function of the Parent Educator. Finally,

professional clerical staff are maintained at six PCC's. These individuals are generally Data Coordinators or Bookkeepers.

Among non-professionals, the largest job category is Teacher Aide. Among Teacher Aides, especially for those who make home visits as part of an outreach program, the distinction between teaching parents and teaching children is so blurred that none has been made. Typically, for in-Center programs, Teacher Aides help the educators with the children. However, in many PCC's they also spend considerable time with parents. In the outreach programs they spend equal time with mothers and with children, because both are met together.

Social Service Aides are reported in 16 Centers. As with their supervisors, their job descriptions vary greatly according to whether they are assigned a case load of families for whom they have primary responsibility under supervision, or whether they have a particular set of functions, e.g. organization of PCC recreational events, arranging for and taking families to appointments, etc.

Nineteen Centers have Health or Food Aides whose job is typically to help prepare and serve the meals to focal children, although they may assist the Nurse as well.

Drivers/Maintenance positions are reported by 30 of the Centers. Drivers bring children and families to and from the Center, and in the majority of Centers take families to their various appointments and activities.

Non-professional clerical positions are maintained at nearly all Centers. These people answer the telephone, type letters and reports, and in most Centers maintain records.

It seems clear that the job description of any individual staff member at a PCC depends on the organization and overall philosophy and operation of that particular Center. Within any two Centers two Child Educators, where one is visiting homes and the other is in the Center, might have less in common than a Child Educator who visits the home would have with a Social Work Aide who is working with mothers in the course of visits to the home. In fact, in one PCC, the Social Work Aides have recently acquired the task of infant stimulation during their visits to the home.

Duration of employment

Below are data on duration of PCC employment.

Table 47 Duration of PCC employment in CCR staff sample.

DURATION	TOTAL SAMPLE	PROFES-SIONALS	NON-PROFES-SIONALS	PRESENT/ FORMER PARENT	NON-PARENT
Under 6 mos.	58 (18%)	33 (21%)	25 (15%)	10 (16%)	15 (14%)
6-18 months	70 (21)	40 (25)	30 (18)	19 (31)	11 (11)
18-30 months	79 (24)	32 (20)	47 (28)	18 (30)	29 (27)
Over 30 months	120 (37)	55 (34)	65 (39)	14 (23)	51 (48)
Base:	327	160	167	61[1]	106

[1] Nine parents were classified as professionals and do not appear in this base.

Among professionals, 46% of those interviewed have been at the PCC for under one and one half years. Among non-professionals, 33% have been there for that length of time. Among parents, turnover is seemingly much greater than it is among non-parent non-professionals. Forty-seven percent of the parents on staff have been so for under one and one half years; only 25% of the non-parents have been there for so short a period.

Conversely, 54% of the professionals and 67% of the non-professionals had been there for more than a year and a half. Among non-professionals only 53% of parents had been on staff for over 18 months; 75% of non-parents have remained for the same period of time.

Inspection of the data provided on the staff section of the Director questionnaire shows that among most professionals the longevity distribution is rather even across the time intervals discussed above. For instance, Parent Educators show no pattern of leaving within any particular length of time. However, there are two exceptions to this evenness of distribution. One is the Directors themselves. There seems to be a decided tendency for them to be either short-term (10 have been on their jobs for fewer than six months) or long-term (11 have been on their jobs for more than 30 months) with relatively few in-between.

Nurses have the shortest PCC employment lives of all. That is only partially a matter of supply and demand. Nurses are generally in short supply, and most Parent-Child Centers cannot afford to match salaries or working conditions available elsewhere. PCC Nurses seem to be a volatile group in other

respects, too. Of 16 reported to have left various Centers, five departed for reasons of poor job fit or incompetence and another three had personal problems. Only five of the 16 left for self-advancement.

Summary of Job Functions

With 32 of 33 PCC's reporting, a total of 680 staff members are mentioned:

1. Nearly three quarters of these are non-professionals; one quarter are professionals.
2. Among professionals, Child Educator is the largest staff category (66 of them at 28 Centers). Eighteen PCC's report 26 Social Service Supervisors; ten report 13 Parent Educators. Sixteen Centers have a Nurse on staff.
3. There are 202 Teacher Aides, with all Centers mentioning at least one of these non-professionals. Sixteen PCC's also report a total of 88 Social Service Aides.
4. Non-professionals have, on the average, remained in their positions longer than professionals -- 67% of the non-professionals have been employed 18 months or more versus 54% for professionals.
5. Nurses have the shortest job durations; Directors tend to be either short-term (ten incumbents have been on staff for fewer than six months) or very long-term (eleven for more than two and one half years).

6. Twenty-four PCC's hire parents as non-professionals, there being 210 parents in total currently on staff -- more than two fifths of all non-professionals.

C. WHAT HAS HAPPENED TO THE NON-PROFESSIONAL STAFF AS A RESULT OF PCC INVOLVEMENT?

Clearly, the most important impact on non-professional staff is the fact that PCC is currently providing a total of 680 full time jobs to poverty area residents. These jobs represent impact not only on those who hold the jobs, but on their families and, by virtue of the classic economic multipliers, on the communities themselves.

Table 48 presents the relative frequency with which PCC's have hired parents or non-parents into current non-professional employment.

Table 48. Number of parents and non-parents among non-professional employees on total PCC staff, according to position.

POSITION	TOTAL	NO. PCC's REPORTING	PARENTS	NON-PARENTS
Teacher Aide	202 (41%)	32	129 (61%)	73 (26%)
Social Service Aide	88 (18)	16	16 (8)	72 (26)
Food/Health Aide	47 (10)	19	19 (9)	28 (10)
Driver/ Maintenance	52 (11)	30	16 (8)	36 (13)
Clerical	58 (12)	30	10 (5)	48 (17)
Other	41 (8)	6	20 (10)	21 (8)
Total	488	32	210	278

These data indicate that parents are filling more than two fifths of all non-professional positions reported. Parents predominate in the Teacher Aide category. Social Service, Driver/Maintenance and Clerical positions tend not be filled by PCC parents. All but nine of the 32 Centers reporting say they hire parents in one capacity or another. Eighteen PCC's employ parents as Teacher Aides, nine as Food or Health Aides, 11 as Drivers/Maintenance, eight as Social Service Aides and seven as Clerical staff.

It is apparent that not only are some parents and community residents able to get jobs through PCC but also that through these jobs they are learning a variety of skills.

Out of the 167 non-professionals in the CCR sample, 112 reported some pre-service training. These data are presented in Table 49 below.

Table 49. Length of pre-service training reported by non-professionals in CCR sample.

LENGTH OF PRE-SERVICE	TOTAL	PRESENT/ FORMER PARENT	NON-PARENT
None	55 (33%)	19 (31%)	36 (34%)
One week or less	22 (13)	11 (18)	11 (10)
1-4 weeks	35 (21)	8 (13)	27 (25)
1-2 months	12 (7)	3 (5)	9 (9)
More than 2 months	43 (26)	20 (33)	23 (22)
Total	167	61	106

The majority of parents and non-parents alike (two out of three) report some pre-service training. One out of three parents and about one out of five other community residents report training of more than two months' duration.

Most staff members who report some pre-service feel that this training was "very helpful" (70%). Only 4% feel the training was not helpful.

Finally, Directors were asked to report the reason for termination of each job position. It was difficult to obtain reliable information on PCC job turnover, and on the reasons for turnover. It seems certain that data on this aspect understate the number of departures by a fair margin. For one thing, many Centers simply have no records on this issue and memory is not necessarily reliable either for number or for reasons underlying termination. In spite of these difficulties, the reported frequencies and reasons for departure among non-professionals appear below.

Table 50. Frequencies and reasons for staff departures among total PCC non-professional staff. (Directors' reports).

DEPARTURE REASONS	NON-PROFESSIONALS
Self-advancement	90 (36%)
Moved from area, change in communities	45 (18)
Personal problems	52 (21)
Poor job fit, incompetence	55 (22)
Other	5 (2)
Total	247

It is risky to draw conclusions from data felt to be at best incomplete. However, if the incompleteness is spread relatively evenly over job categories, then a very important aspect of PCC impact can be inferred. Self-advancement is certainly a major reason for leaving. Add to this category those whose families moved, sometimes for better employment of a husband, and there emerges a decided picture of departure for positive reasons.

While it is true that PCC staff turnover is relatively high, nevertheless the average non-professional stays for a mean number of 23 months. For those who are able to learn and to move on to better jobs, movement is positive. There is no evidence to suggest that families suffer unduly if a staff member leaves. Psychiatric residents, psychological interns and social workers in their field placements leave their patients after one year and move on. While a relationship of greater duration might be desirable, training needs of professionals have always taken precedence over service in this sense. If non-professional staff are to receive training, perhaps a fairly steady flow through PCC is necessary and even desirable.

Summary

It can be said that a substantial number of PCC parents and community residents obtain jobs through the PCC, receive training and learn new skills, and then move on to other jobs. This represents both economic and psychological impact on the

employees, their families, and on the communities in which they live.

Comparison between KAI and CCR staff data

Staffing patterns appear to be changing within the PCC project:

1. KAI reported one professional to every four non-professionals. Now that ratio is one to two and one half. However, that change may simply reflect KAI's stricter interpretation of professionalism along lines of academic attainment.
2. There is a change in component emphasis apparent in staffing proportions by function. For example, KAI reported that 12 PCC's employed a total of 24 Child Educator professionals, and that 23 Centers hired 115 Teacher Aides. CCR find that 28 PCC's now have Child Educators and that 27 Centers list a total of 202 Teacher Aides. That increase in child development staffing is associated with modestly lesser emphases on social service, medical, and purely administrative functions.
3. The total number of employees has remained fairly level -- 698 two years ago against 680 now (with one PCC not reporting and Alaska not included in the survey). The ratio of paid staff to enrolled families is holding rather level at approximately one to 2.5.

4. KAI reported 146 parents on staff. CCR shows that figure now to be 210 -- fully two fifths of non-professional complements. Additionally, there are a handful of present or former parents filling professional positions, according to CCR's interpretation.

5. The staff turnover rate is still high. Kirschner found that 27% of all original employees had left within the first program year. CCR data, known to be incomplete because of inexact record-keeping or reports from memory, show that total turnover to date may be equal to or greater than the number of all present incumbents. However, now as before, self-advancement seems to be the most major reason for leaving.